90-1277

No. _____

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IN THE

Supreme Court of the United States

October Term, 1990

CHARLES R. CRAMER, JR., ET AL
Petitioners,

versus

ASSOCIATION LIFE INSURANCE COMPANY, INC.
Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF THE STATE OF LOUISIANA

PETITION FOR CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

1. Did the Supreme Court of Louisiana err in determining that Petitioners' claims for penalties and mandatory attorney's fees pursuant to La. R.S. 22:657 are preempted by the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C.A. § 1001, *et seq.* (ERISA).

2. Is the dictum in this Court's *Pilot Life* decision so encompassing as to allow insurance companies, in an insured ERISA plan (as opposed to a self-funded plan) to escape all state statutory regulation of insurance claims-handling, especially in view of the fact that the Department of Labor (which has jurisdiction over ERISA) does not regulate insurers' claim handling, thereby creating a complete regulatory vacuum for insurance companies?

3. Should this Court re-review congressional intent concerning preemption of state insurance laws in *insured* ERISA plans, in view of:

   a. This Court's recent decision of *FMC Corporation v. Holliday;*
   b. Recent congressional statement on its legislative intent contrary to the dictum in *Pilot Life;* and,
   c. The ever-growing national problem that has arisen?

PARTIES TO THE PROCEEDING

Pursuant to Rule 21.1(b), counsel for Petitioners certifies that the following are parties to this proceeding:

Mr. Charles R. Cramer, Jr., Petitioner

Mrs. Neva Gage Cramer, Petitioner

Association Life Insurance Company, Inc., Respondent

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The decision of the Louisiana Supreme Court incorrectly extended the decision of this Court in *Pilot Life Insurance Company v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987) to apply to the facts of the present case. The issue of pre-empting state insurance statutes which clearly are designated to regulate insurance claims handling has not been previously decided by this Court. Petitioners respectfully submit that this issue is one of significant and national proportions.

If the Louisiana Supreme Court's analysis of the McCarran-Ferguson three-prong test is correct regarding what constitutes an insurance "regulation" for purposes of ERISA's saving clause, there is not a single claim-handling statute which will survive such scrutiny. Pre-emption of such claim-handling statutes will leave the door open to massive abuses by insurers. The purpose of ERISA, to benefit the participants of employee welfare benefit plans, is substantially eroded by this decision of the Louisiana Supreme Court. Indeed, all

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similar state statutes regulating claims handling *by insurers* would be nullified as applied to most group policies.

This Court recently made explicitly clear in its decision in *FMC Corp. v. Holliday*, ___ U.S. ___, ___ S.Ct. ___ (November 27, 1990) that a distinction is to be drawn between insured plans and self-funded plans. *Insured* ERISA plans are subject to indirect state regulation of the insurers issuing policies to such ERISA plans. The facts of this case provide this Court an opportunity to delineate the effect of state insurance claim-handling statutes on insurers which issue policies to ERISA plans.

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No._____

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1990

CHARLES R. CRAMER, JR., ET AL
Petitioners,

versus

ASSOCIATION LIFE INSURANCE COMPANY, INC.
Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF THE STATE OF LOUISIANA

PETITION FOR CERTIORARI

Petitioners, Charles R. Cramer, Jr. and Neva Gage Cramer, respectfully pray that a writ of certiorari issue to review the judgment of Louisiana Supreme Court rendered November 8, 1990.

OPINIONS BELOW

The opinion of the Louisiana First Circuit Court of Appeals is reported at 563 So.2d 267 (La. App. 1st Cir. 1990) and appears herein as Appendix A. The case before the Louisiana Supreme Court is cited as Charles R. Cramer, Jr. and Neva Gage Cramer v. Association Life Insurance Company, number 90-CC-0804 (November 1990) ___ So.2d ___ (La.1990) and appears herein as Appendix B.

JURISDICTION

The judgment of the Supreme Court of Louisiana was entered on November 8, 1990, and this petition for certiorari was filed within ninety (90) days of that date. This Court's jurisdiction is invoked under 28 U.S.C §1257(3).

STATUTES WHICH THIS CASE INVOLVES

This case involves the following statutes:

La. R. S. 22:2;

La. R. S. 22:657 (set forth in Appendix G);

29 U.S.C. §1144(a) (pre-emption clause) (set forth in Appendix G);

29 U.S.C. §1144(b)(2)(A) (saving clause) (set forth in Appendix G);

29 U.S.C. §1144(b)(2)(B) (deemer clause) (set forth in Appendix G)

15 U.S.C. §1011 and 1012 (provision of McCarran-Ferguson Act) (set forth in Appendix G)

STATEMENT OF THE CASE

This suit was filed on September 24, 1986, and is a claim for health insurance benefits under a group health insurance policy purchased by the employer of petitioner, Charles Cramer, Jr. The policy was purchased by the employer from Respondent, Association Life Insurance Company, Inc., (ALIC) (see affidavit of Charles Cramer, Sr. at Appendix E). Petitioners' daughter had incurred extraordinary medical expenses at Texas Childrens Hospital in Houston, Texas prior to her death on November 17, 1985, at that facility. After their claim for payment of medical expenses was denied by Respondent, Petitioners filed suit to recover those benefits.

In addition to the claim for payment of the medical expenses, Petitioners also plead that Respondents should pay a penalty of double the amount of the medical expenses together with mandatory attorney's fees under La. R.S. 22:657. On or about November 7, 1988, approximately two (2) months before the scheduled jury trial in this matter, Respondents filed an Amended and Supplemental Answer (see appendix C) pleading that Petitioners did not have a cause of action for penalties and mandatory attorney's fees under La. R.S. 22:657, alleging that such claims were preempted by the Employee Retirement Income Security Act of 1974, (ERISA), 88 Stat. 829, as amended, 29 U.S.C. §1001 *et seq*.

On December 15, 1988, Respondent filed an Exception of No Cause of Action or Alternatively Motion for Partial Summary Judgment, (see Appendix D) claiming that Petitioners' state law claims were preempted and displaced by the civil enforcement remedies of ERISA. At the same time, Respondent filed a Motion *in Limine* requesting that the trial court deny Petitioners' demand for a jury trial as such was precluded by ERISA. Petitioners filed a cross motion for Partial Summary Judgment opposing Respond-

ent's Exception and Motion and requesting an Order from the court that ERISA, as a matter of law, was not applicable to the instant case (see Appendix E).

The trial court denied Respondent's exception and motions and granted Petitioners' motion in holding that ERISA was not applicable in this case (see Judgment of trial court at Appendix F). The trial court also denied Respondent's Motion *In Limine*, thereby preserving Petitioners' right to a jury trial.

Respondent, ALIC, applied to the Court of Appeal, First Circuit, State of Louisiana for a Writ of Certiorari to review the trial court's ruling. The Court of Appeal issued a Writ of Certiorari to review the trial court's ruling on the following issues:

> 1. Whether ERISA applied at all to the present case, thus requiring the application of its civil enforcement provisions and thus preempting Petitioners' claim for penalties and mandatory attorney's fees under La. R.S. 22:657;
>
> 2. Should ERISA apply, are Plaintiffs precluded from trial by jury; and
>
> 3. If ERISA applies, are Plaintiffs entitled to *de novo* trial court review.

The Court of Appeal held that:

> 1. ERISA applies to the present case because an ERISA "employee benefit plan" existed at the time Plaintiffs' claims arose;
>
> 2. Plaintiffs' claim for penalties and mandatory attorney's fees under La. R.S. 22:657 was not preempted by ERISA;
>
> 3. Plaintiffs were entitled to a jury trial on the issues of the penalties and attorney's fees under La. R.S. 22:657; and

4. Plaintiffs were entitled to a trial *de novo* and the arbitrary and capricious standard was not applicable.

Respondent (defendant below) applied to the Louisiana Supreme Court for Supervisory Writs challenging the Court of Appeal's holding that Plaintiffs' state law claims for penalties and mandatory attorney's fees under La. R.S. 22:657 were not pre-empted and also challenging the ruling that Plaintiffs were entitled to a jury trial of that claim under 22:657. The Louisiana Supreme Court held that La. R.S. 22:657 was preempted by ERISA because it failed to meet the *McCarran-Ferguson* criteria and because it conflicts with the civil enforcement provisions of ERISA. The Louisiana Supreme Court reversed the Court of Appeal's denial of Respondent, ALIC's, Motion for Partial Summary Judgment and remanded the case to the trial court for further proceedings in accordance with that ruling.

ARGUMENT AMPLIFYING REASONS FOR GRANTING THE WRIT

I. Issue

As this court has indicated in *Pilot Life Ins. Co. v. Dedeaux*, 481, U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987), the pre-emptive effect of ERISA is set forth in the oft quoted pre-emption, saving and deemer clauses set forth in Appendix G.

> To summarize the pure mechanics of the provisions quoted above: If a state law "relate[s] to . . . employee benefit plan[s]," it is pre-empted. §514(a). The saving clause excepts from the pre-emption clause laws that "regulat[e] insurance." §514(b)(2)(A). The deemer clause makes clear that a state law that "purport[s] to

> regulate insurance" cannot deem an employee benefit plan to be an insurance company. §514(b)(2)(B) *Pilot Life*, 481 U.S. at 45, 107 S.Ct. at 1552.

The issue in the present case is whether the saving clause above excepts from the pre-emption clause La. R.S. 22:657 as a law which "regulates insurance". The Louisiana Supreme Court relied heavily on the *Pilot Life* decision and on *Metropolitan Life Ins. Co. vs. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985) in holding that R.S. 22:657 is preempted by ERISA. Petitioners respectfully submit that *Pilot Life* and *Metropolitan Life* do not compel such a result.

II. The *Pilot Life* common-sense/McCarran-Ferguson Act analysis of ERISA's pre-emption of a state common law cause of action does not compel the conclusion that La. R.S. 22:657 is likewise pre-empted.

A. *Pilot Life* analysis of the common-sense/McCarran-Ferguson Act considerations.

In *Pilot Life*, the issue was whether ERISA pre-empted a state *common law* tort and contract action asserting improper processing of a claim for benefits under an insured employee benefit plan. *Pilot Life*, 481 U.S. at 43, 107 S.Ct. at 1150-1551.

Because the common law causes of action asserted in Dedeaux's complaint clearly *related to* an ERISA employee benefit plan and were therefore pre-empted under §514(a) (29 U.S.C. §1144(a)), unless those causes of action fell under an exception to §514(a) they were expressly pre-empted. *Pilot Life* 481, U.S. at 48, 107 S.Ct. at 1553. Those causes of action would be saved from pre-emption only if they were laws "which regulate insurance" as contemplated by §514(b)(2)(A) (saving clause) (29 U.S.C. §1144(b)(2)(A)).

In determining whether the common law causes of action were laws which regulated insurance, this court in *Pilot Life* first referred to considerations it had made in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985).[1] Describing its analysis in *Metropolitan Life*, the court in *Pilot Life* indicated "[f]irst, we took what guidance was available from a 'common-sense view' of the language of the saving clause itself . . . Second, we made use of the case law interpreting the phrase 'business of insurance' under the McCarran-Ferguson Act, 15 U.S.C. §1001 *et seq.*, in interpreting the saving clause." *Pilot Life*, 481 U.S. at 48, 107 S.Ct. at 1553. The court went on to enumerate the three criteria used in determining whether an activity falls under the McCarran-Ferguson Act "business of insurance":

> *[F]irst*, whether the practice has the effect of transferring or spreading a policy holder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry." *Pilot Life*, 481 U.S. at 48 and 49, 107 S.Ct. 1553-1554 (citing *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129, 102 S.Ct. 3002, 3009, 73 L.Ed.2d 647 (1982) (emphasis in original).

This court stated "[a] common-sense view of the word 'regulates' would lead to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, but be specifically directed toward that industry." *Pilot Life*, 481 U.S. 50, 107 S.Ct. at 1554. The court concluded that a common-sense

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[1] The pertinent issue in *Metropolitan Life* was whether a Massachusetts statute requiring specific minimum mental-health-care benefits was saved from pre-emption by the saving clause. See discussion beginning at *Metropolitan Life*, 105 S.Ct. at page 2389.

understanding of the phrase "regulates insurance" would not support the argument that the Mississippi common law of bad faith falls under the saving clause since any breach of contract, and not just the breach of an insurance contract, could lead to liability for punitive damages under Mississippi law. *Id.*

In addressing the three McCarran-Ferguson criteria, the court first determined that the Mississippi common law of bad faith did not effect a spreading of policyholder risk. *Id.* The court also determined that the Mississippi law's connection to the insurer-insured relationship was "attenuated at best." The court noted that unlike the mandated-benefits law in *Metropolitan Life* the Mississippi common law of bad faith did not define the terms of the relationship between the insurer and insured. Finally, the court noted that the Mississippi law of bad faith developed from general principles of tort and contract law available in any Mississippi contract case and thus, that law at most met only one of the three McCarran-Ferguson Act "business of insurance" criteria. 481 U.S. 51, 107 S.Ct. 1555.

B. Application of *Pilot Life* and *Metropolitan Life* Analysis to La. R.S. 22:657.

La. R.S. 22:657 is a provision of the Louisiana Insurance Code, the stated legislative purpose of which is to regulate the insurance business in all its phases. La. R.S. 22.2 (See Appendix G). See *Soniat v. Travelers Insurance Company,* 538 So.2d 210, 214 (La. 1989). The Louisiana Insurance Code is a body of statutory law which does not simply have an impact on the insurance industry, ". . . but is specifically directed to that industry." *Soniat,* 538 So.2d at 214. It thus appears that in applying the *Pilot Life/ Metropolitan Life* analysis to §657 a common-sense understanding of the phrase "regulates insurance" supports the argument that §657 falls under the saving clause.

Likewise, with respect to the third criterion of the McCarran-Ferguson Act (whether the practice is limited to entities within the insurance industry) §657 seems to clearly satisfy that factor as well. At page 7 of its opinion, the Louisiana Supreme Court agreed that this third factor was met by §657.

With respect to the first McCarran-Ferguson criterion (the risk transference factor), the Louisiana Supreme Court found that the statute does not serve to spread a policyholder's risk in the context of an insurance policy. While risk transference or spreading is not effected in the traditional or ordinary sense, Petitioners suggest that a policyholder's risk is actually transferred only in the event that a valid claim is paid promptly and in full. Since §657 serves to encourage and enforce the prompt and full payment of legitimate claims, it can be said that the statute does have the effect of at least promoting or enhancing the ordinary risk transference.

With respect to the second McCarran-Ferguson criterion, decisions of this court interpreting the McCarran-Ferguson Act are persuasive in determining the meaning of the phrase "integral part of the policy relationship." In attempting to arrive at the meaning of the words "business of insurance" in the McCarran-Ferguson Act the Court in *Securities & Exchange Commission v. National Securities, Inc.*, 393 U.S. 453, 460, 89 S.Ct. 564, 568, 21 L.Ed. 2d 668 (1969) stated:

> The relationship between insurer and insured, the type of policy which could be issued, its *reliability, interpretation,* and *enforcement* — these were the *core* of the "business of insurance." . . . But whatever the exact scope of the statutory term, it is clear where the focus was — it was on the *relationship* between the insurance company and the policyholder. Statutes aimed at pro-

> tecting or regulating this relationship, directly or indirectly are laws regulating the "business of insurance." (Emphasis added.)[2]

If the "reliability, interpretation and enforcement" of a policy are at the "core of the 'business of insurance'," then surely §657, which insures the reliability of a policy and helps insure its accurate interpretation and also enforces the prompt and fair payment of valid claims, must be an integral part of the policy relationship between the insurer and the insured. The essence of the relationship between the insurer and insured is the payment of claims. Regardless of the terms of any health insurance contract, if valid claims are not properly and timely adjusted and paid then the contract is of no effect. The Louisiana Supreme Court, in relying on *Pilot Life*, determined that §657 was not an integral part of the insurer/insured relationship since it did not affect *substantive* provisions of the insurance contract. However, as the language of *Securities & Exchange Commission* above reveals, the relationship between the insured and insurer goes beyond the mere terms of the policy. Statutes which directly or indirectly affect the reliability, interpretation and enforcement of the policy are integral to (at the core of) that relationship.

As this court in *Securities & Exchange Commission* further indicated in explaining the passage of the McCarran-Ferguson Act: "[o]bviously Congress' purpose was broadly to give support to the

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[2] The McCarran-Ferguson Act was passed in response to the United States Supreme Court's decision in *United States v. South-Eastern Underwriters Assn.*, 322 U.S. 533, 64 S.Ct. 1162, 88 L.Ed. 1440 (1944). Before that decision it was generally thought that the regulation of insurance transactions rested exclusively with the states. In *South-Eastern Underwriters*, however, the Supreme Court held that insurance transactions were subject to federal regulation under the Commerce Clause. Congress responded with the passage of the McCarran-Ferguson Act. *Securities and Exchange Commission v. National Securities, Inc.*, 393 U.S. 453, 89 S.Ct. 564.

existing and future state systems for regulating and taxing the business of insurance." 393 U.S. at 458, 89 S.Ct. at 568. Citing *Prudential Insurance Co. v. Benjamin*, 328 U.S. 408, 429, 66 S.Ct. 1142, 90 L.Ed. 1342 (1946). Regarding those existing state systems for regulating the business of insurance, prior to the enactment of the McCarran-Ferguson Act, Louisiana and other states had statutes providing for the payment of punitive damages and/or attorney's fees by insurance companies which failed to timely pay claims or which were in bad faith in investigating and paying those claims. Eleven such state statutes are referred to in 1 G COUCH, *CYCLOPEDIA OF INSURANCE LAW*, 538-542 (1930) and 7 G COUCH, *CYCLOPEDIA OF INSURANCE LAW* 6190-6210 (1930). See also 48 Harvard L. R. 319-327 (1934) which lists thirteen state statutes which then regulated the business of insurance with attorney's fee and/or punitive damages provisions. This court has also considered such statutes. In at least one such case the Court seemed to acknowledge the regulation of insurance by such state statutes. In *Life & Casualty Ins. Co. of Tennessee v. McCray*, 291 U.S. 566, 54 S.Ct. 482, 78 L.Ed. 987 (1934) the Court, in considering the constitutionality of an Arkansas statute providing for a 12% penalty and attorney's fee for an insurance company's failure to timely pay a claim, stated:

> The statute was enacted in 1905, and the insurance was written in 1930. Here at the delivery of the policy, the insurer was informed that if it failed to make payment in accordance with its contract, "twelve per cent damages" would be owing to the insured. We discover nothing arbitrary or oppressive in imposing such a contract upon the business of insurance, a business subject, as all agree, to control and regulation. 291 U.S. at 570, 54 S Ct. at 484. (citations omitted).

Petitioners submit that states have traditionally regulated the business of insurance with insurance *statutes* similar to La. R.S. 22:657 and Congress, in passing the McCarran-Ferguson Act,

recognized the continuing validity of such forms of insurance regulation. This Court in *Metropolitan Life, supra,* has also recognized that laws regulating claims practices are a common form of insurance regulation. 471 U.S. at 728, 105 S.Ct. at 2383, footnote 2.

Commentators have since also recognized that the states still regulate insurance through such statutes. See for example, R. KEETON, *BASIC INSURANCE LAW* 541 (1960); A. WIDASS, *INSURANCE — MATERIALS ON FUNDAMENTAL PRINCIPLES, LEGAL DOCTRINES AND REGULATORY ACTS* 919 (1989).[3]

It is difficult to imagine a more integral part of the relationship between the insured and insurer than a law which insures that all valid claims will be paid in a timely fashion . Even if the claim is paid eventually, but not timely, the insured will likely have been subjected to damaged credit, mental anguish at a time when he or she can least deal with it and possibly denial of additional timely treatment as a result of non-payment of existing medical bills.

Accordingly, Petitioners submit that §657 meets the "common-sense" test and the three criteria (although the relationship to the first criterion is somewhat attenuated) of the McCarran-Ferguson Act as discussed in *Pilot Life* and *Metropolitan Life*. §657 should therefore be saved from pre-emption. The same result should be reached even if one of the three McCarran-Ferguson criteria are not met as "[n]one of these criteria is necessarily determinative in itself . . ." *Union Labor Life Ins. Co. v. Pireno,* 458 U.S. 119, 129, 102 S.Ct. 3002, 3009, 73 L.Ed.2d 647 (1982).

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[3] See also for example: Calif. Ins. Code §790.03(h) *et seq.;* Colo. Rev. Stat. §10-3-1104(1)(h)(I)(2XIV); Fla. Stat. Sec. 624.155; Ill. Rev. Stat. Ch. 73, Par. 767 (§155 of the Illinois Insurance Code); Mass. Gen'l. Laws Ann. Ch. 17D (West 1979 and Supplement 1986); Tenn. Ins. Code 56.7.105; Texas VATS. Ins. Code art. 3.62 (article 3.62 of Texas Insurance Code).

It is especially critical that the Louisiana Supreme Court's analysis of the McCarran-Ferguson three-prong test, as applied to insurance statutes which regulate claims-handling practices, be disapproved. As the above discussion indicates, if the test is applied exactly as by the Louisiana Supreme Court, there is not a single claims-handling statute which would survive such scrutiny. Yet, the "common sense" test clearly supports the conclusion that statutes dealing with claims-handling are properly part of the regulation of the industry. More frightening, as discussed in the Conclusion, *infra*, pre-emption of claims-handling statutes will leave the door open to massive abuses by insurers and will result in defeating ERISA's expressed purpose of protecting beneficiaries.

The determination that this state insurance code statute should be saved from ERISA pre-emption is bolstered by this Court's recent decision in *FMC Corporation v. Holliday*, ___ U.S. ___, ___ S. Ct. ___, (November 27, 1990). In *FMC*, this Court made it unquestionably clear that insurers who sell policies to employers cannot thereby obtain the benefit of escaping from state insurance regulatory statutes on the basis of ERISA pre-emption. As the *FMC* decision noted:

> An insurance company that insures a plan remains an insurer for purposes of state laws "purporting to regulate insurance" after application of the deemer clause. *The insurance company is therefore not relieved from state insurance regulation*. The ERISA plan is consequently bound by state insurance regulations insofar as they apply *to the plan's insurer*. 59 United States Law Week at 4012. (Emphasis added.)

Later, the *FMC* decision states:

> . . . the saving clause retains the independent effect of protecting state insurance regulation of insurance contracts purchased by employee benefit plans. *Id*.

It is critical to note that the Petitioners' action is *not* brought against the employee benefit *plan*. It is brought against an insurer which sold a policy, for a premium, to an employer for the benefit of the employees. There is no reason why the insurer, doing business as an insurance company and not as an ERISA benefit plan, should be able to pull the veil of ERISA pre-emption over its conduct and escape the mandates of the insurance claims-handling statutes enacted by the Louisiana legislature. The *FMC* decision hammered this home by stating:

> Our interpretation of the deemer clause makes clear that *if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts*, . . . *Id.* (Emphasis added.)

The Louisiana Supreme Court ignored this critical distinction between regulation of an ERISA *plan* and regulation of an *insurer* who sold its policy to an ERISA plan. Since both the saving clause and this Court's decision in *FMC* make it clear that the insurer may not escape its statutory obligations merely because the purchaser of its policy is an employer or an ERISA plan, the Louisiana Supreme Court's decision is clearly wrong and must be reversed.

The Louisiana Supreme Court did not end its decision with its analysis of the McCarran-Ferguson criteria, however. The court further examined the comprehensive civil enforcement scheme of ERISA as it understood that scheme to have been set forth in *Pilot Life*. For the reasons set forth below, Petitioner submits that this *Pilot Life* analysis should not be applied to the facts of this case.

III. If La. R.S. 22:657 is determined to be a law which regulates insurance within the meaning of the McCarran-Ferguson Act, that Louisiana statute should not still be pre-empted by the civil enforcement provisions of ERISA.

Pertinent provisions of the McCarran-Ferguson Act (Act March 9, 1945, Ch 20, 59 Stat. 33) provide as follows:

§1011. *Declaration of Policy.*

The congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States. 15 U.S.C. §1011.

§1012. *Regulation by State law; Federal law relating specifically to insurance; applicability of certain Federal laws after June 30, 1948.*

(a) *State regulation.* The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) *Federal regulation.* No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: . . . 15 U.S.C. §1012.

If La. R.S. 22:657 regulates insurance within the meaning of the McCarran-Ferguson Act, then "[n]o Act of Congress" (ERISA) "shall be construed to invalidate, impair, or supersede" that statute.

ERISA at 29 U.S.C. §1144(d) provides:

(d) *Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of the United States prohibited.* Nothing in this title shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in §111 [29 U.S.C. §1031] and §507(b) [29 U.S.C. §1137(b)]) or any rule or regulation issued under any such law.

If Louisiana's statute is determined to be one which regulates insurance within the meaning of the McCarran-Ferguson Act; and if the Louisiana Supreme Court's interpretation of the *Pilot Life* intent-of-Congress/exclusive-remedy argument is correct, then the asserted intent of Congress in enacting ERISA has been construed to "invalidate, impair or supersede" a state law that regulates the business of insurance, in direct violation of the express language of the McCarran-Ferguson Act. Under that Act a state law either regulates insurance or it does not. The Louisiana Supreme Court's interpretation of *Pilot Life* in effect means that congressional-intent in ERISA must be identified *first* in order to interpret the language of "business of insurance" in the McCarran-Ferguson Act. This strained interpretation of ERISA and the McCarran-Ferguson Act in *Pilot Life* does not have to be reached if the congressional intent/exclusive-remedy argument of *Pilot Life* is held to the facts of that case alone. There exists an important distinction between the two cases that justifies such a limitation. *Pilot Life* dealt with a state *common* law, which is not an *enactment*, and therefor seems not to run afoul of 15 U.S.C. §1012(b). On the other hand, 22:657 was enacted by the Louisiana legislature for the express purpose of regulating insurance.

The effect of the exclusive remedy argument is to amend the saving clause (29 U.S.C. §1144(b)(2)(A)) to read as follows:

> "Except as provided in subparagraph (B) [the deemer clause], nothing in this title, *except §1132* shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities."

Thus, that argument seems to be in direct conflict with the statute itself.

The Louisiana Supreme Court examined ERISA's civil enforcement scheme as distinct from the pre-emption issue and erroneously determined that permitting the legislatively mandated penalty to apply to the insurer in this case would disrupt Congress's intent in enacting ERISA and in providing for exclusive remedies.

First, there is no justification for carving out ERISA's remedies provisions for enforcement where the saving clause clearly applies Second, it is submitted that the language in *Pilot Life* regarding the limitation on remedies in ERISA cases was not necessary to that decision and further, it has been contravened by recent congressional statements.

Since the *Pilot Life* decision, there has been considerable judicial and congressional dissatisfaction with the limitation of remedies available under current interpretations of 29 U.S.C. §1132. In 1989 the Committee on Education and Labor took the opportunity to address congressional concerns regarding ERISA's remedies provisions. As set forth in the House Report:

> In recent years the Committee has received numerous complaints and inquiries from Members of Congress and their constituents about improper denials of medical claims, improper denials of continuation coverage, or unreasonable delays in processing claims by employers or insurers. Participants in ERISA-covered employee benefit plans that have been treated in this manner are concerned that the Supreme Court's interpretation of ERISA (particularly as articulated in *Pilot Life Insurance Co. v. Dedeaux*, 107 S.Ct. 1549 [481 U.S. 41, 95 L.Ed.2d 30] (1987) as pre-empting state laws that authorize punitive or other extracontractual damages in connection with claims for benefits effectively denies them of legal recourse. The Committee shares their concern.
>
> In *Pilot Life*, the Supreme Court held that state common law claims against an insurance company for breach of contract and bad faith arising out of an improper denial

of disability benefit claims under an ERISA-covered plan were pre-empted. In addition, the Supreme Court declined to fashion a Federal common law remedy for improper processing of benefit claims, holding that ERISA's civil enforcement provision under §502 were intended to be the exclusive remedies afforded to plan participants and beneficiaries. The Committee disagrees with this latter conclusion.

The Committee believes that the legislative history of ERISA and subsequent expansions of ERISA support the view that Congress intended for the courts to develop a Federal common law with respect to employee benefit plans, including the development of appropriate remedies, even if they are not specifically enumerated in §502 of ERISA. Since the issue of pre-emption and civil remedies under ERISA is within the exclusive purview of the labor committees of Congress, the Committee has, over the years, considered the option of amending the statute to encompass specifically several additional remedies. In light of the legislative history on this issue, however, the Committee believes such action is unnecessary.

The Committee reaffirms the authority of the Federal courts to shape legal and equitable remedies to fit the facts and circumstances of the cases before them, even though those remedies may not be specifically mentioned in ERISA itself. In cases in which, for instance, facts and circumstances show that the processing of legitimate benefit claims has been unreasonably delayed or totally disregarded by an insurer, an employer, a plan administrator, or a plan, the Committee intends the Federal courts to develop a Federal common law of remedies, drawing upon principles enunciated in state law, including such remedies as the awarding of punitive

> and/or compensatory damages against the person responsible for the failure to pay claims in a timely manner (House Report, 101-247, pages 55-56).

In light of this strong congressional statement, the Louisiana Supreme Court's concern that enforcing the state regulatory penalties would improperly override ERISA's enforcement scheme was misplaced. Since Congress is now calling loud and clear, for more expansive civil remedies in ERISA cases, the Louisiana statutory scheme fulfills, rather than derogates, Congress' intent to protect ERISA beneficiaries. Since the regulatory penalties provided under La. R.S. 22:657 promote ERISA's purposes, there is no conflict in applying the statutory penalties to an insurer which sells a policy to an ERISA plan.

IV. A pre-emption of La R.S. 22:657 would not promote the policy underlying ERISA but would deprive of substantial protection the very persons ERISA was enacted to benefit.

In §1001 (congressional findings and declaration of policy) of ERISA, Congress expressed that the purpose of ERISA is to protect the interests of employees and their beneficiaries in employee benefit plans.

In paragraph (b) of §1001, Congress declared it to be the policy of ERISA ". . . to protect interstate commerce and the interest of participants in employee benefit plans and their beneficiaries . . . ."

In the *Pilot Life* decision, the Supreme Court agreed with the Solicitor General's argument that varying state causes of action for claims within the scope of 28 U.S.C. §1132(a) would pose an obstacle to the purposes and objective of Congress. *Pilot Life*, 481 U.S. at 52, 107 S.Ct. at 1555.

However, a subsequent exposition by this Court regarding the pre-emptive features of ERISA supports a finding that pre-emption of La. R.S. 22:657 does not further the purpose of ERISA pre-emption. In *Fort Halifax Packing Company, Inc. v. Coyne*, 482 U.S. 1, 107 S.Ct. 2211, 96 L.Ed.2d 1 (1987), the court considered the pre-emptive effect of ERISA on a Maine statute requiring employers to provide a one-time severance payment to employees in the event of a plant closing. In holding that the one-time severance payment to employees did not constitute an ERISA "employee benefit plan," the court analyzed the purpose and policy behind ERISA's pre-emption provisions:

> This point was emphasized in *Shaw, supra*, where we said with respect to another form of State regulation, "[o]bligating the employer to satisfy the varied and perhaps conflicting requirements of particular state fair employment laws . . . would make administration of a nationwide plan more difficult." 463 U.S., at 105 n. 25, 103 S.Ct. at 2904, n. 25. Such a situation would produce considerable inefficiencies, which the employer might choose to offset by lowering benefit levels. As the Court in *Shaw* indicated, "ERISA's comprehensive pre-emption of state law was meant to minimize this sort of interference with the administration of employee benefit plans," *ibid.*, so that employers would not have to "administer their plans differently in each State in which they have employees." (Citing *Shaw v. Delta Airlines, Inc.* 463 U.S. at 105, 103 S.Ct. at 2904 (1983)).
>
> * * *
>
> Congress intended pre-emption to afford employers the advantages of a uniform set of administrative procedures governed by a single set of regulations. This concern only arises, however, with respect to benefits

> whose provision by nature requires an ongoing administrative program to meet the employer's obligation. It is for this reason that Congress pre-empted state laws regulating *plans*, rather than simply to *benefits*. Only a plan embodies a set of administrative practices vulnerable to the burden that would be imposed by a patchwork scheme of regulation. *Fort Halifax Packing*, 107 S.Ct. at 2217.

This discussion by the Supreme Court in the *Fort Halifax* decision seems to indicate the court's belief that the pre-emption provisions of ERISA were intended to protect employers in *the administration* of *welfare benefit plans* from multiple state regulations. The importance of such pronouncements to the instant case is that the administrators of plans which *purchase insurance*, as acknowledged in *FMC Corporation*, are in no way adversely impacted by state laws which regulate insurance companies' claims processing procedures such as §657 in Louisiana. *Only the insurer itself is affected*. The employer/administrator is not inconvenienced or adversely affected at all simply because the insurer is required to promptly and fairly process claims at the risk of having to pay punitive damages. As the language above indicates, Congress pre-empted state laws relating to *plans rather* than simply to *benefits*. *Id*. In *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982) the 11th Circuit Court of Appeals noted that "[t]he *purchase of insurance* is only a method of implementing a plan, fund or program and is evidence of the existence of a plan but *is not itself a plan*." (Emphasis added.) 688 F.2d at 1375. Since La. R.S. 22:657 regulates only the activities of the insurer and does not regulate the plan itself or the activities of the administrator, there is no reason that statute should not be saved from pre-emption as such a conclusion would not advance any purpose of pre-emption in the first place.

As held in *FMC Corporation*, laws affecting benefit plans, for example, self-insured plans, are still pre-empted under this analysis. The "deemer clause" (29 U.S.C. §1144(b)(2)(B)) provides that plans themselves shall not be deemed to be insurance companies for purposes of any state law purporting to regulate insurance.

The distinction between regulatory control of ERISA *plans* and regulatory control of *insurers* which issue policies *to* ERISA plans is critically important in light of the ability and effectiveness of the regulatory agencies charged with the duty and obligation to control abuses.

Under the McCarran-Ferguson Act, insurers are subject to regulatory control solely as provided under state law. Thus, the Federal regulatory agency charged with the duty to regulate ERISA plans, the Department of Labor, has no ability or incentive to attempt to control insurance claims-handling abuses engaged in by insurance companies.

This distinction between regulation of insurers and regulation of ERISA plans was made crystal clear in the *FMC Corporation* decision. As noted above, *FMC Corporation* stands resolutely for the proposition that an insurer should and must remain subject to regulation by the individual states' Legislatures.

Additionally, the fact that insurance companies would be subjected to certain disuniformities from state to state would not preclude the "saving" of §657. As the Supreme Court stated in *Metropolitan Life, supra*, "[s]uch disuniformities, however, are the inevitable result of the congressional decision to 'save' local insurance regulation. Arguments as to the wisdom of these policy choices must be directed at Congress." 481 U.S. at 747, 105 S.Ct. at 2393.

On the contrary, while no purpose of pre-emption would be advanced, the very purpose and objective of ERISA itself, to protect employees and their dependents, would be severely impaired. As discussed earlier, one of the most important features of the insurance agreement is the payment of claims. Yet the pre-emption of statutes such as §657 takes from employees the single most effective weapon at their disposal to insure the fair and prompt payment of legitimate claims. Without such a tool of enforcement the ERISA beneficiaries are literally at the mercy of insurance carriers who could with impunity delay the payment of legitimate benefits. As discussed earlier, a delay in payment could often have disastrous consequences on the beneficiaries ERISA was designed to protect.

CONCLUSION

ERISA was enacted to provide protection to individuals who had been abused by underfunded pension plans and irresponsible fiduciaries. (See generally, 29 U.S.C. §1144; H.R. Rep. No. 807, 93rd Cong., 2d. Sess., reprinted in 1974 U.S. Code Cong. & Admin. News 4670, 4678-9, 4680 ("House Report No. 807"); S. Rep. No. 383, 93rd Cong., 2d. Sess., reprinted in 1974 U.S. Code Cong. & Admin. News 4899 ("Senate Report No. 383"). In applying ERISA to employee pension and welfare benefit plans, Congress did not *displace* any existing effective control or regulation of insurance companies. Rather, Congress created a whole new regulatory system for handling pension and welfare benefit plans. In doing so, Congress carefully and explicitly exempted insurance companies from the regulatory effect of ERISA's provisions and entrusted regulation of insurers to the highly developed system of control already well established by the individual states.

Surely, if Congress had intended to upset this existing system of regulation, it would have done so in express and unambiguous terms.

A national problem has arisen for employees who are having difficulty getting medical claims paid timely and honorably by insurance companies that sell policies to ERISA plans. This problem has risen to such an extent that it has been the subject of a CBS television *60 Minutes* program documenting the many tragedies that are now occurring. (See Transcript, Volume XXIII, Number 9, attached as Appendix H.)

Congressman Howard Berman of the House Judiciary Committee relayed the devastating national impact the limitation in ERISA remedies has had on the average person. As he noted in the interview with "60 Minutes," broadcast November 11, 1990 (See Transcript, Volume XXIII, page 1 of Appendix H) "[w]e are getting a tremendous increase in the number of complaints from people about arbitrary cancellations, illegal refusals to pay health claims, hospital bills, doctor's bills." Congressman Berman concluded that "[a]s long as there are no penalties for unconscionable refusals to pay a claim or arbitrary decisions to cancel policies, [insurers] are in fat city." (p. H-6 of Appendix H.)

Absent this Court's reevaluation of Congress' intent regarding the remedies available under 29 U.S.C. §1132, the only refuge ERISA plan beneficiaries have against insurance company abuses are state insurance code claims-handling provisions. People who have medical problems and are in hospitals have enough to deal with emotionally without having to do battle with their own insurance carrier over a medical claim. As a practical matter, they have no meaningful remedy under ERISA. Most medical claims are in the $500 to $10,000 range. Victims of unfair claims practices have difficulty finding lawyers who are willing to go to Federal Court under ERISA on such small damages matters.

Furthermore, there is no administrative process set up by the Department of Labor to handle grievances leveled at insurance companies. This has always been handled under state laws. Surely, it was not the intent of this Court, nor Congress, to wipe off the books all statutes (some, such as La. R.S. 22:657, having been in effect for decades) dealing with unfair insurance claims practices for insurance policies under group plans.

There need be no conflict between ERISA remedy and enforcement provisions and state insurance code provisions and protections. As unequivocally delineated in *FMC Corporation,* ERISA relates to *plan* benefits, state insurance codes protect *insureds* and relate to *insurance benefits*.

We now have the rather incredible situation where an insurance company could commit intentional fraud against a disabled employee, inflict severe mental distress on a disabled victim, as well as substantial economic losses (apart from the policy benefits themselves), and the law provides no remedy. This certainly could not have been the result intended by Congress. This cannot be this Court's intent. However, absent a clear declaration by this Court that insurance company claims-handling practices remain subject to the scrutiny of state insurance code provisions, the abuses will continue. The abuses will accelerate. The tragedies will mount. Eventually, most insured persons in this country will be touched by the problem.

After this Court's decision in *FMC Corporation,* the time is ripe for drawing a bright line between regulation of ERISA plans and regulation of insurance company claim practices. The former properly falls under ERISA. The latter, just as properly, is best left to state regulation.

Petitioners, respectfully request that the decision of the Louisiana Supreme Court be reversed and this court declare that La. R. S. 22:657 is not pre-empted by ERISA.

Respectfully submitted:

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 5th day of February, 1991, three copies of the Petition for Writ of Certiorari were delivered to Counsel for Respondents, Christine Lipsey at One American Place, 23rd floor, Baton Rouge, Louisiana 70825, Post Office Box 3197, Baton Rouge, Louisiana 70821. I further certify that all parties required to be served have been served.

/s/Allen M. Posey, Jr.
Counsel for Petitioners

APPENDICES

APPENDIX A

CHARLES R. CRAMER, JR. AND NEVA GAGE CRAMER v. ASSOCIATION LIFE INSURANCE COMPANY, INC.

No. CW 89 0057.

Court of Appeal of Louisiana,
First Circuit.

March 15, 1990.

Employee brought action against insurer under employer's health plan for failure to pay benefits. The Nineteenth Judicial District Court, East Baton Rouge Parish, Joseph F. Keogh, J., held for employee on issue of applicable law, and certiorari review was sought. The Court of Appeal, Carter, J., held that Louisiana statute, requiring payment of properly submitted insurance claims and imposing sanctions for improper delay in payment, came within ERISA preemption provision's saving clause for statutes regulating insurance, and thus was applicable in employee's suit against insurer under employer's health plan.

Writ denied in part and made peremptory in part.

Edwards and Foil, JJ., concurred and filed opinions.

Lanier, J., concurred in part and dissented in part and filed opinion in which LeBlanc, J., joined.

Allen M. Posey, Jr., Baton Rouge, for plaintiffs.

Christine Lipsey, Baton Rouge, for defendant.

Before EDWARDS, CARTER, LANIER, LeBLANC and FOIL, JJ.

CARTER, Judge.

This is a suit in contract to recover health insurance benefits.

FACTS

On September 24, 1986, plaintiffs, Charles and Neva Cramer, Jr., filed suit against defendant, Association Life Insurance Company, Inc. (ALIC), claiming benefits due under a health insurance policy purchased by Mr. Cramer's employer, Advertising By Computer, Inc. (ABC). In their petition, the Cramers alleged the following facts, in pertinent part:

2.

On or about July of 1985, ADVERTISING BY COMPUTER, INC. (hereinafter sometimes referred to as "Advertising"), a Louisiana domestic corporation, made an application for health and medical insurance benefits with Defendant, Association Life Insurance Company, Inc.

3.

The group insurance application by Advertising was approved by Defendant effective August 1, 1985. The assigned group number of that policy is 11709 and the unit number is 9425.

4.

Plaintiff, Charles R. Cramer, Jr., as an employee of Advertising, together with his wife, Neva Gage Cramer (Plaintiff) and minor daughter, Noel Cramer, were covered under the health and medical insurance benefits of defendant's group policy.

5.

After the effective date of August 1, 1985, Plaintiffs' minor daughter, Noel Cramer, became very ill and was treated first at Earl K. Long Memorial Hospital in Baton Rouge, Louisiana and was later transferred to Texas Children's Hospital, Houston, Texas, for treatment.

6.

On September 14, 1985 Noel was diagnosed as suffering from severe combined immune deficiency.

7.

On September 24, 1985 Noel first received treatment for the severe combined immune deficiency, undergoing bone marrow transplantation.

8.

On November 16, 1985, Noel passed away as a result of this severe combined immune deficiency.

. . . .

12.

From September through December, 1985, Plaintiffs submitted copies of all the [medical] bills . . . [incurred by Noel], with requests that Defendant pay those medical expenses.

13.

Despite this amicable demand Defendant has failed and/or refused to pay any of the foregoing medical expenses.

In addition to their claim for unpaid benefits, the Cramers alleged that ALIC was arbitrary and capricious in its failure to pay their claim, thereby entitling them to recover a penalty of 100% of the principal amount sued on and reasonable attorney's fees, pursuant to LSA-R.S. 22:657. ALIC, in its original answer, denied any obligation to the Cramers. ALIC filed an amended and supplemental answer pleading that the Cramers do not have a cause of action for penalties and mandatory attorney's fees under LSA-R.S. 22:657 because such claims are preempted by the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C.A. § 1001, *et seq.* (ERISA).

On December 15, 1988, ALIC filed a peremptory exception raising the objection of no cause of action, or, alternatively, a motion for partial summary judgment claiming that the Cramers' claim for statutory penalties under LSA-R.S. 22:657 was preempted by ERISA. ALIC also filed a motion *in limine* requesting that the trial court deny the Cramers' demand for a jury trial because the case is governed by ERISA and the federal common law interpreting ERISA, which precludes a trial by jury. ALIC further moved for an *in limine* order limiting the evidence admissible at trial to that evidence which was before ALIC at the time its final claim decision was rendered, as provided for by ERISA.

The Cramers filed a cross motion for partial summary judgment, opposing ALIC's exception and motion for summary judgment, and requested an order of the court declaring that ERISA is inapplicable to the case.

The trial court ruled that ERISA was inapplicable to this case and rendered judgment, which overruled ALIC's exception, denied ALIC's motion for summary judgment and motions *in limine*, and granted the Cramers' motion for summary judgment. ALIC sought supervisory writs. This court issued a writ of certiorari to review the trial court's ruling on the following issues:

A. Does the Employment Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C.A. §§ 1001, *et seq.*, apply to the case at bar, thus requiring the application of ERISA's civil enforcement provisions contained in 29 U.S.C.A. § 1132 and thereby preempting and displacing the plaintiffs' state law claims for breach of contract and penalties and mandatory attorneys' fees under La. R.S. 22:657?

B. If ERISA applies to the case at bar, are the plaintiffs precluded from having a jury trial?

C. If ERISA applies to the case at bar, shouldn't the evidence at trial be limited to that before ALIC at the time of its final claims decision, thus precluding a *de novo* trial court review, and requiring application of an arbitrary and capricious standard of review to the claims decision made by ALIC?

APPLICABILITY OF ERISA

ALIC contends that ERISA applies to the health insurance policy purchased by ABC, thus requiring the application of ERISA's civil enforcement provisions contained in 29 U.S.C.A. § 1132 and, thereby, preempting the Cramers' state law claims for breach of contract and statutory penalties under LSA-R.S. 22:657.

To determine whether an insurance plan is governed by ERISA, the following analysis set forth in *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir.1982), should be followed:

I.

Congress enacted ERISA to protect working men and women from abuses in the administration and investment of private retirement plans and employee welfare plans. Broadly stated, ERISA established minimum standards for vesting of benefits, funding of benefits,

carrying out fiduciary responsibilities, reporting to the government and making disclosures to participants. *See generally* H.R.Rep. No. 93-533, 93d Cong. 2d Sess., *reprinted in* [1974] U.S. Code Cong. & Ad. News 4639.

With a few specific exceptions . . ., Title I of ERISA applies to any "employee benefit plan" if it is established or maintained by any employer or employee organization engaged in commerce or in any industry or activity affecting commerce, or by both an employer and an employee organization. ERISA § 4(a), 29 U.S.C. § 1003(a). "Employee benefit plan" or "plan" means an "employee welfare benefit plan" or an "employee pension benefit plan" or a plan which is both a welfare plan and a pension plan. ERISA § 3(3), 29 U.S.C. § 1002(3).

. . . .

II.

ERISA § 3(1), 29 U.S.C. § 1002(1), defines "employee welfare benefit plan" or "welfare plan" as

any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in § 302(c) of the

> Labor Management Relations Act, 1947 (other than pensions on retirement or death, and insurance to provide such pensions).[4]

By definition, then, a welfare plan requires (1) a "plan, fund, or program" (2) established or maintained (3) by an employer or by an employee organization, or by both, (4) for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death, unemployment or vacation benefits, apprenticeship or other training programs, day care centers, scholarship funds, prepaid legal services or severance benefits (5) to participants or their beneficiaries.

A.

Prerequisites (3), (4) and (5) are either self-explanatory or defined by statute. A plan, fund, or program must be established or maintained "for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise," health, accident, disability, death, or unemployment or vacation benefits or apprenticeship or other training programs, day care centers, scholarship funds, prepaid legal services or severance benefits.[5]

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[4] The ERISA definition refers to benefits in § 302(c) of the Labor Management Relations Act, 1947 (codified at 29 U.S.C. § 186(c).) The Secretary in regulations says § 302, 29 U.S.C. § 186(c), duplicates to a large extent the benefits enumerated in ERISA § 3(1)(A), 29 U.S.C. § 1002(1)(A), except that § 302, 29 U.S.C. § 186(c), adds holiday and severance benefits. 29 C.F.R. § 2510.3-1(a)(3).

[5] A plan, fund or program furnishing both benefits listed in ERISA § 3(1), 29 U.S.C. § 1002(1) or § 302(c) of the Labor Management Relations Act, 29 U.S.C. § 186(c), and benefits not listed in those sections is subject to ERISA to the extent the plan, fund or program has as its purpose the providing of the enumerated benefits.

The gist of ERISA's definitions of employer,[6] employee organization,[7] participant,[8] and beneficiary,[9] is that a plan, fund, or program falls within the ambit of ERISA only if the plan, fund, or program covers ERISA participants because of their employee status in an employment relationship, and an employer or employee organization is the person that establishes or maintains the plan, fund, or program. Thus, plans, funds, or programs under which no union members, employees or former employees participate are not employee welfare benefit plans under Title I of ERISA. *See* 29 C.F.R. 2510.3-3(b),(c).

B.

Not so well defined are the first two prerequisites: "plan, fund, or program" and "established or maintained." Commentators and courts define "plan, fund, or program" by synonym — arrange-

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[6] The term "employer" means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity. ERISA § 3(5), 29 U.S.C. § 1002(5).

[7] The term "employee organization" means any labor union or any organization of any kind, or any agency or employee representation committee, association, group, or plan, in which employees participate and which exists for the purpose, in whole or in part, of dealing with employers concerning an employee benefit plan, or other matters incidental to employment relationships; or any employees' beneficiary association organized for the purpose in whole or in part, of establishing such a plan. ERISA § 3(4), 29 U.S.C. § 1002(4).

[8] The term "participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit. ERISA § 3(7), 29 U.S.C. § 1002(7). The term "employee" means any individual employed by an employer. ERISA § 3(6), 29 U.S.C. § 1002(6).

[9] The term "beneficiary" means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder. ERISA § 3(8), 29 U.S.C. § 1002(8).

ment, scheme, unitary scheme, program of action, method of putting into effect an intention or proposal, design — but do not specify the prerequisites of a "plan, fund, or program." At a minimum, however, a "plan, fund, or program" under ERISA implies the existence of intended benefits, intended beneficiaries, a source of financing, and a procedure to apply for and collect benefits.

"Established or maintained" appears twice in the definition of an employee welfare benefit plan: first, an employer or employee organization or both must establish or maintain a plan, fund, or program, and second, the plan, fund, or program must be established or maintained for specified purposes. In many instances a plan is established or maintained, or both, in writing. It is obvious that a system of providing benefits pursuant to a written instrument that satisfies ERISA §§ 102 and 402, 29 U.S.C. §§ 1022 and 1102, would constitute a "plan, fund or program."

ERISA does not, however, require a formal, written plan. ERISA's coverage provision reaches "*any* employee benefit plan if it is established or maintained" by an employer or an employee organization, or both, who are engaged in any activities or industry affecting commerce. ERISA § 4(a), 29 U.S.C. § 1003(a) (emphasis added). There is no requirement of a formal, written plan in either ERISA's coverage section, ERISA §4(a), 29 U.S.C. § 1003(a), or its definitions section, ERISA § 3(1), 29 U.S.C. § 1002(1). Once it is determined that ERISA covers a plan, the Act's fiduciary and reporting provisions do require the plan to be established pursuant to a written instrument, ERISA §§ 102 and 402, 29 U.S.C. §§ 1022 and 1102; but clearly these are only the responsibilities of administrators and fiduciaries of plans covered by ERISA and are not prerequisites to coverage under the Act. Furthermore, because the policy of ERISA is to safeguard the well-being and security of working men and women and to apprise them of their rights and obligations under any employee benefit plan, *see* ERISA § 2, 29 U.S.C. § 1001, it would be incongruous for persons establishing or maintaining informal or unwritten employee benefit plans, or assuming the responsibility of safeguarding plan assets,

to circumvent the Act merely because an administrator or other fiduciary failed to satisfy reporting or fiduciary standards. *Accord, Dependahl v. Falstaff Brewing Corp.*, 491 F.Supp. 1188, 1195 (E.D.Mo.1980), *aff'd* 653 F.2d 1208 (8th Cir.1981).

. . . .

A decision to extend benefits is not the establishment of a plan or program. Acts or events that record, exemplify or implement the decision will be direct or circumstantial evidence that the decision has become reality — e.g., financing or arranging to finance or fund the intended benefits, establishing a procedure for disbursing benefits, assuring employees that the plan or program exists — but it is the reality of a plan, fund or program and not the decision to extend certain benefits that is determinative.

In determining whether a plan, fund or program (pursuant to a writing or not) is a reality a court must determine whether from the surrounding circumstances a reasonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits. Some essentials of a plan, fund, or program can be adopted, explicitly or implicitly, from sources outside the plan, fund, or program— e.g., an insurance company's procedure for processing claims, *cf.* 29 C.F.R. § 2520.102-5 (qualified health maintenance organization) — but no single act in itself necessarily constitutes the establishment of the plan, fund, or program. For example, the purchase of insurance does not conclusively establish a plan, fund, or program, but the purchase is evidence of the establishment of a plan, fund, or program; the purchase of a group policy or multiple policies covering a class of employees offers substantial evidence that a plan, fund, or program has been established.[11]

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[11] Department of Labor regulations recognize that an employer may be involved in a plan, fund, or program without establishing or maintaining it. *See* 29 C.F.R. § 2510.3-1(j). According to the regulation the term "employee welfare benefit plan" does not include group insurance if the sole functions of the employer are, without endorsing the program, to permit an insurer to publicize a program to employees, to collect premiums through payroll deductions, and to

C.

In summary, a "plan, fund, or program" under ERISA is established if from the surrounding circumstances a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits. To be an *employee* welfare benefit plan, the intended benefits must be health, accident, death, disability, unemployment or vacation benefits, apprenticeship or other training programs, day care centers, scholarship funds, prepaid legal services or severance benefits; the intended beneficiaries must include union members, employees, former employees or their beneficiaries; and an employer or employee organization, or both, and not individual employees or entrepreneurial businesses, must establish or maintain the plan, fund, or program.

[688 F.2d at 1370-1373]

[1] The record shows that Mr. Cramer's employer, ABC, through its president, Charles Cramer, Sr., made an application for group life, health, and medical insurance with ALIC. The group insurance application by ABC was approved by ALIC and became effective on August 1, 1985. Charles Cramer, Jr., an employee of ABC, together with his wife and minor daughter were covered under the group policy, as were other employees of ABC, their spouses, and their dependents. According to ABC's application, ABC contributed 50% of the cost of the employee benefits.

Under the factors set forth in *Donovan*, we find that ABC established an employee benefit plan for the purpose of purchasing insurance. The extended benefits were provided to the employees

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remit the premiums to the insurer, and the employer does not contribute premiums to the insurer or make a profit from the program. *See also Hamberlin v. VIP Insurance Trust*, 434 F.Supp. 1196 (D.Ariz.1977) (policies sold directly to individual employees; employers had no voice in management and contributed no funds).

of ABC, their spouses, and their dependents. Fifty percent of the insurance premiums were paid by ABC, and ABC, not the individual employees, maintained the plan.

Accordingly, we find that the ABC plan is an employee welfare benefit plan within the contemplation of ERISA and that the trial court erred in finding to the contrary. However, the inquiry does not end here.

PREEMPTION OF LSA-R.S. 22:657 AND THE STATE CAUSE OF ACTION BY ERISA

Having determined that ERISA is applicable to the instant case, we must determine whether the preemption provision of ERISA, 29 U.S.C. § 1144, precludes application of LSA-R.S. 22:657, the state law upon which the Cramers rely for relief.

[2] The provisions of ERISA relating to preemption include the preemption clause in § 1144(a), the saving clause in § 1144(b)(2)(A), and the deemer clause in § 1144(b)(2)(B), which set forth the framework for determining whether any state law is preempted by ERISA, and provide as follows:

> Except as provided in subsection (b) of this section [the saving clause], the provisions of this subchapter and subchapter III of this chapter **shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . .** (Emphasis added)

29 U.S.C. § 1144(a).

> Except as provided in subparagraph (B) [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

29 U.S.C. § 1144(b)(2)(A).

> Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. § 1144(b)(2)(B).

Generally, ERISA preempts all state laws insofar as they relate to any employee benefit plan and saves from preemption any state law which regulates insurance. Moreover, a state law which regulates insurance cannot deem an employee benefit plan to be an insurance company for the purposes of regulation.

[3] The jurisprudence interpreting "the business of insurance" as used in the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et. seq.*, (the federal statute which gave the states the power to regulate the business of insurance) has identified three relevant criteria for determining whether a statutory provision falls within the saving clause and is not preempted: first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry. *Union Labor Life Insurance Company v. Pireno,* 458 U.S. 119, 129, 102 S. Ct. 3002, 3008, 73 L. Ed.2d 647 (1982). *See also Group Life & Health Insurance Company v. Royal Drug Company,* 440 U.S. 205, 99 S. Ct. 1067, 59 L.Ed.2d 261 (1979).

In enacting the McCarran-Ferguson Act, Congress was concerned with the type of state regulation that focuses on the contract of insurance. The relationship between the insurer and the insured, the type of policy which could be issued, its reliability, its interpretation, and its enforcement were the core of the "business of

insurance." The focus of the term "business of insurance" was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the "business of insurance." *Securities and Exchange Commission v. National Securities, Inc.* 393 U.S. 453, 89 S. Ct. 564, 568-569, 21 L.Ed.2d 668 (1969). *See generally Metropolitan Life Insurance Company v. Massachusetts,* 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985).

[4] In the instant case, the Cramers seek relief under LSA-R.S. 22:657, which provides, in pertinent part, as follows:

> A. All claims arising under the terms of health and accident contracts issued in this state . . . shall be paid not more than thirty days from the date upon which written notice and proof of claim, in the form required by the terms of the policy, are furnished to the insurer unless just and reasonable grounds, such as would put a reasonable and prudent business man on his guard, exist. The insurer shall make payment at least every thirty days to the assured during that part of the period of his disability covered by the policy or contract of insurance during which the insured is entitled to such payments. Failure to comply with the provisions of this Section shall subject the insurer to a penalty payable to the insured of double the amount of the health and accident benefits due under the terms of the policy or contract during the period of delay, together with attorney's fees to be determined by the court. The district court of the parish where the insured lives or has his domicile shall have jurisdiction to try such cases.

Analyzing this provision in light of the McCarran-Ferguson test, we find that the statute satisfies all three criteria and is saved from preemption. First, the statute has the effect of transferring or spreading policyholder risks in that the provisions of LSA-R.S. 22:657 are incorporated by law into each policy of accident and

health insurance and is available to all said policyholders. The risks of an insurer being arbitrary and capricious are spread among all policyholders and the benefits are available to all policyholders. Second, the practice of enforcing the payment of properly submitted claims within a reasonable period is an integral part of the policy relationship between the insurer and insured. The policy relationship between a health and accident insurer and its insured is based upon the insurer's obligation to pay, in a timely fashion, all properly submitted claims for covered medical expenses in exchange for the insured's prompt payment of all insurance premiums. Further, LSA-R.S. 22:657 appears in Title 22 of the Louisiana Revised Statutes and is part of Louisiana's Insurance Code. The stated legislative purpose of the Insurance Code was to "regulate insurers and the insurance business." *See* Acts 1958, No. 125, which reenacted and amended the Insurance Code, LSA-R.S. 22:1 *et seq*. Third, the practice of permitting recovery of penalties and attorney's fees pursuant to LSA-R.S. 22:657 is limited to entities within the insurance industry in that the statutory penalties provided by LSA-R.S. 22:657 are not available in any other contract case. Clearly, LSA-R.S. 22:657 regulates the "business of insurance" and is precisely the type of state law which ERISA's saving clause intended to save from preemption.

We recognize that there are three federal district court decisions in the State of Louisiana holding that LSA-R.S. 22:657 A is preempted by ERISA. *See Taylor v. Blue Cross/Blue Shield of New York*, 684 F. Supp. 1352 (E.D.La. 1988); *Sublett v. Premier Bankcorp Self Funded Medical Plan*, 683 F.Supp. 153 (M.D. La.1988); *Rasmussen v. Metropolitan Life Insurance Company*, 675 F.Supp. 1497 (W.D. La.1987). However, all of these decisions were rendered by the federal district courts prior to the Louisiana Supreme Court decision in *Soniat v. Travelers Insurance Company*, 538 So.2d 210 (La.1989). In *Soniat*, the Louisiana Supreme Court considered the issue of preemption in interpreting an insurance provision dealing with cancellation for nonpayment of premiums. In finding that the cause of action under LSA-R.S. 22:213 B(7) was not preempted by ERISA, the Court stated:

> In the present case, the Soniats sought to apply a provision of the Louisiana Insurance Code in order to recover benefits allegedly due under the group plan. La.R.S. 22:213 B(7) is part of a body of statutory law which does not just have an impact on the insurance industry, but is specifically directed to that industry. It therefore is clearly a state law which regulates insurance. Moreover, the remedies sought in this case, unlike the common law causes of action asserted in *Pilot Life, [Insurance Company v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987)], are not available in every other Louisiana contract case.
>
> The stated legislative purpose of the Insurance Code was to "regulate insurers and the insurance business." See Acts 1958, No. 125, which reenacted and amended the Insurance Code, La.R.S. 22:1 et seq. The statute at issue thus regulates the business of insurance. This is precisely the type of state law which ERISA's saving clause intended to save from pre-emption. Of further significance are the facts that the state law at issue does not conflict with the substantive provisions of ERISA and that the application of La.R.S. 22:213 B(7) does not create a conflict with ERISA's civil enforcement scheme. (Footnotes omitted)
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> [538 So.2d at 214-215]

Further, although the court in *Soniat* did not address whether LSA-R.S. 22:657 was preempted by ERISA because it set aside the award of attorney's fees on other grounds, the general tenor of the opinion supports the position that ERISA does not preempt LSA-R.S. 22:657. In expressly holding that the Insurance Code regulates the business of insurance, the Louisiana Supreme Court in *Soniat* apparently disagreed with the federal district court cases holding that the insurance code provision (LSA-R.S. 22:657) is not a law regulating the business of insurance within the meaning of ERISA's saving clause.

ERISA was enacted by Congress to insure that employees covered under employee benefit plans received the benefits to which they are entitled. If the penalty provisions provided by state statute (LSA-R.S. 22:657) are preempted, there is little to prevent a defendant insurer from arbitrarily denying claims, undermining ERISA's original goal to protect employees from abusive plans, and the saving clause of ERISA, saving from preemption all state statutes regulating the business of insurance, is meaningless.

Therefore, we find that the plaintiffs have a cause of action to recover health insurance benefits and any available punitive or compensatory damages, specifically those provided in LSA-R.S. 22:657. To hold otherwise would violate the most fundamental of all substantial policies of ERISA, viz. to protect the interest of the employee.

JURY TRIAL

[5] Plaintiffs' petition states a cause of action for recovery of benefits under both ERISA and provisions of Louisiana's Insurance Code. Plaintiffs are entitled to a jury trial of those issues pertaining to benefits under the Louisiana Insurance Code, but are not entitled to a trial by jury of all other issues governed by ERISA. *See* LSA-C.C.P. arts. 1731, 1732, 1736. *Cf. Lavergne v. Western Company of North America, Inc.*, 371 So.2d 807 (La.1979);[1] *Dean v. Terrebonne Parish Police Jury*, 510 So.2d 82 (La.App. 1st Cir.1987); *Hebert v. Diamond M. Company*, 367 So.2d 1210 (La.App. 1st Cir.1978), *amended and affirmed*, 385 So.2d 410 (La.App. 1st Cir.1980).

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[1] LSA-C.C.P. art. 1732(6) has recently been amended to preclude a jury trial in an admiralty or general maritime claim under federal law that is brought in state court under a federal "savings to suitor" clause if the plaintiff has designated that suit as an admiralty or general maritime claim. *See Bruce Heinhuis, et al v. Venture Associates, Inc. of Louisiana, et al*, 558 So.2d 1244 (La.App. 1st Cir.1990).

Therefore, as in the case of suits against the State of Louisiana and other defendants who have the right to jury trial, the trial court will be required to conduct a bifurcated trial with the judge making all determinations as to ERISA questions and the jury determining the issues not preempted by ERISA, namely penalties and attorney's fees under LSA-R.S. 22:657. *Cf. Dean v. Terrebonne Parish Police Jury, supra.*

BURDEN OF PROOF IN EVIDENTIARY MATTERS

[6] ALIC contends that it is a fiduciary under the plan governed by ERISA and, as such, the appropriate standard of judicial review is the arbitrary and capricious standard. We disagree. In the instant case, ALIC certainly could not be considered an impartial decision-maker and clearly would have a conflict of interest. It would be ludicrous to give the defendant insurance company quasi-judicial authority to decide whether to perform under its own contract.

Therefore, although the arbitrary and capricious standard of review may be appropriate where the issue is whether a trustee has correctly balanced valid competing interests among present and future benficiaries of the plan or in matters of true expertise such as investment decisions, it is clearly inappropriate for the issues presented in the case *sub judice*.[2]

The trial court was correct in denying ALIC's motion *in limine* that the only evidence that can be considered was that which was before ALIC at the time ALIC rendered its final claims decision. The bifurcated trial should proceed in accordance with the procedural laws and rules of evidence available in other state court proceedings.

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[2] *See Bass v. Retirement Plan of Conoco, Inc.*, 676 F.Supp. 735 (W.D.La.1988). *See also Bruch v. Firestone Tire & Rubber Co.*, 828 F.2d 134 (3rd Cir.1987). *Cf. also Gilliam v. Plan Administrator, Retirement Plan of International Paper Company for Union Represented Employees (Group A)*, 506 So.2d 1305 (La.App. 2nd Cir.1987); *Morein v. Reading and Bates Drilling Company, Inc.*, 469 So.2d 389 (La.App. 3rd Cir.1985).

CONCLUSION

Therefore, for the above and foregoing reasons, the writ is denied in part and made peremptory in part; the judgment of the trial court is affirmed insofar as it overruled defendant's exception of no cause of action and denied ALIC's motion for summary judgment on the issue of plaintiffs' claim for penalties and attorney's fees under LSA-R.S. 22:657.

Further, the judgment of the trial court is affirmed insofar as it granted plaintiffs' motion for summary judgment decreeing as a matter of law plaintiffs' claim for penalties and attorney's fee is not preempted by ERISA and that plaintiffs are entitled to a jury trial on those issues with the burden of proof and evidentiary laws in accordance with the procedural laws of the State of Louisiana. Insofar as the judgment of the trial court on plaintiffs' motion for summary judgment held that other provisions, except those set forth above, are governed by ERISA, the granting of the motion for summary judgment is reversed.

WRIT DENIED IN PART AND MADE PEREMPTORY IN PART.

EDWARDS, J., concurs. I will admit confusion as to what is and what is not a "plan" within the meaning of ERISA. If the mere purchase of group medical insurance is a plan, with the resulting bureaucratic ramifications, then 1990 has been superseded by *1984*. I concur with the result in this opinion because I believe it conforms with the law of this state and is, certainly, preferable to the opposite result.

FOIL, J., concurs. I would affirm the trial judge's decision.

LANIER, J., concurs in part and dissents in part and assigns reasons.

LeBLANC, J., concurs in part and dissents in part for reasons assigned by LANIER, J.

LANIER and LeBLANC, JJ., concurring in part and dissenting in part.

APPLICABILITY OF ERISA

We agree with the holding of the lead opinion that "the ABC plan is an employee welfare benefit plan within the contemplation of ERISA and that the trial court erred in finding to the contrary."

PREEMPTION OF LA.R.S. 22:657 AND THE LOUISIANA CONTRACT CAUSES OF ACTION BY ERISA

ALIC argues that the Cramers' state law cause of action for breach of contract and their cause of action for statutory penalties under La.R.S. 22:657 are preempted by ERISA. Under Louisiana law, the cause of action for statutory penalties under La.R.S. 22:657 is separate and distinct from the cause of action for breach of the insurance contract. *Cantrelle Fence and Supply Company, Inc. v. Allstate Insurance Company,* 515 So.2d 1074 (La.1987). The lead opinion holds that "the plaintiffs have a cause of action under state law to recover health insurance benefits and any available punitive or compensatory damages, specifically those provided in LSA-R.S. 22:657, notwithstanding that there is concurrent jurisdiction with federal district courts over ERISA regulated plans."

The lead opinion is in error in holding that ERISA applies to the ABC plan but that ERISA does not preempt "the plaintiffs . . . cause of action under state law to recover health insurance benefits." 29 U.S.C.A. § 1144(a). If ERISA is applicable, it applies to control the Cramers' cause of action for *benefits* under the plan, and the state law cause of action therefor is preempted; ERISA's civil remedy is exclusive. *Pilot Life Insurance Company v. Dedeaux,* 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987).

The lead opinion also erroneously holds that the cause of action for statutory penalties under La.R.S. 22:657 has not been preempted. The lead opinion recognizes that three federal district courts in Louisiana have held that La.R.S. 22:657 is preempted by ERISA. *Taylor v. Blue Cross/Blue Shield of New York,* 684 F.Supp.

1352 (E.D.La.1988); *Sublett v. Premier Bancorp Self Funded Medical Plan*, 683 F.Supp. 153 (M.D.La.1988); *Rasmussen v. Metropolitan Life Ins. Co.*, 675 F.Supp. 1497 (W.D.La.1987). When interpreting a federal statute, state courts must look to the latest expression of the federal courts to determine its meaning. *Morris v. Transworld Drilling Company*, 365 So.2d 46 (La.App. 3rd Cir.1978); *Jefferson Manufacturing Company v. Bayou Shoppe*, 210 So.2d 912 (La.App. 2nd Cir.1968). *See also Leyser v. Chicago, Rock Island & Pacific Railroad Company*, 77 So.2d 87 (La.App. 1st Cir.1954); *Morris Lake & Son v. Strickland*, 55 So.2d 51 (La.App. 1st Cir.1951). The lead opinion has declined to recognize that Louisiana's Third Circuit Court of Appeal has held that La.R.S. 22:657 is preempted by ERISA. In *Smith v. Guardian Life Insurance Company*, 546 So.2d 320, 322 (La.App. 3rd Cir.1989) appears the following:

> In *Pilot Life*, the United States Supreme Court made it crystal clear that the civil enforcement provisions of ERISA as contained in § 502(a) were the *exclusive* vehicle for actions by ERISA participants and beneficiaries; and that various state causes of action which fall within the scope of and/or conflict with § 502(a) are pre-empted. We find La.R.S. 22:657(A) provides a remedy both within the scope of and in conflict with § 502(a) and thus is pre-empted by ERISA.
>
> We are aware of the Louisiana Supreme Court's decision in *Soniat v. Travelers Insurance Company, et al*, 538 So.2d 210 (La.1989), but find *Soniat* inapplicable because in that case the court found that the state law at issue did not conflict with the substantive provisions of ERISA.

The Congress of the United States has enacted ERISA. If ERISA is applicable to this case, we, as judges, are obligated to apply it. La. Const. of 1974, art. X, § 30; La.R.S. 42:161. Further, as a state court, we must look to the latest expressions of the federal courts in determining the meaning of ERISA because it is a federal

statute. The federal district courts in Louisiana have held ERISA is applicable in this type of case. The Louisiana Court of Appeal for the Third Circuit agrees. We find this authority persuasive.

RIGHT TO JURY TRIAL

No right to a trial by jury exists under ERISA on an action to recover benefits, or to clarify or enforce rights under an employee welfare benefit plan. *Howard v. Parisian, Inc.*, 807 F.2d 1560 (11th Cir. 1987), and the cases cited therein; *Calamia v. Spivey*, 632 F.2d 1235 (5th Cir.1980). Because we believe the Cramers' state law claims are preempted by ERISA we would hold that the Cramers are not entitled to a trial by jury.

STANDARD OF REVIEW

The Cramers are entitled to a trial de novo because ALIC's denial of coverage is not based on an exercise of discretion. *Firestone Tire and Rubber Company v. Bruch*, 489 U.S. 101, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989); *Schultz v. Metropolitan Life Insurance Company*, 872 F.2d 676 (5th Cir.1989).

A trial de novo in a judicial proceeding means a trial anew or from the beginning. *Scott v. Moore*, 214 La. 1090, 39 So.2d 741 (1949). The court tries the case as in a court of original jurisdiction. *State v. Bickham*, 208 La. 1026, 24 So.2d 65 (1945). At a trial de novo, the whole case is open for decision. *Town of Sulphur v. Stanley*, 207 La. 1075, 22 So.2d 655 (1945); *City of Minden v. Harris*, 196 La. 1021, 200 So. 449 (1941). At a trial de novo the whole case is retried as if no prior trial whatever had been had. *Pardue v. Stephens*, 558 So.2d 1149 (La.App. 1st Cir.1989); Black's Law Dictionary 1349 (5th ed. 1979).

ALIC's assignment of error on this issue is without merit.

APPENDIX B

SUPREME COURT OF LOUISIANA

No. 90-CC-0804

CHARLES R. CRAMER, JR. AND
NEVA GAGE CRAMER

versus

ASSOCIATION LIFE INSURANCE COMPANY

ON WRIT OF CERTIORARI TO THE
COURT OF APPEAL, FIRST CIRCUIT

COLE, Justice.

FACTS

On September 24, 1986, plaintiffs, Charles and Neva Cramer, Jr., filed suit against defendant, Association Life Insurance Company, Inc. (ALIC), claiming benefits due under a health insurance policy purchased by Mr. Cramer's employer, Advertising By Computer, Inc. (ABC). Plaintiffs also sought penalties and reasonable attorney's fees pursuant to La. R.S. 22:657 because of defendant's alleged arbitrary and capricious failure to pay their claim. Defendant, in its original answer, denied any obligation to plaintiffs. In an amended and supplemental answer, defendant asserted plaintiffs do not have a cause of action for penalties and mandatory attorney's fees under La. R.S. 22:657 because such claims are preempted by the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C.A. § 1001, *et seq.* (ERISA).

On December 15, 1988, defendant filed the peremptory exception raising the objection of no cause of action, and, alternatively, a motion for partial summary judgment, claiming plaintiffs' claim for statutory penalties and attorney's fees under R.S. 22:657 was

preempted by ERISA. At the same time, defendant filed a motion *in limine* requesting the trial court to deny plaintiffs' demand for a jury trial because the case is governed by ERISA and the federal common law interpreting ERISA precludes a trial by jury. Plaintiffs filed a cross motion for partial summary judgment, opposing defendant's exception and motion for summary judgment, and requested an order of the court declaring ERISA inapplicable to the instant case.

The trial court ruled that ERISA was inapplicable to the instant case, denied defendant's exception, denied defendant's motion for partial summary judgment and its motion *in limine* to preclude a jury trial, and granted plaintiffs' motion for summary judgment. Defendant then applied for supervisory writs to the Court of Appeal, First Circuit. The Court of Appeal issued a writ of certiorari to review the trial court's ruling on the following issues:

> 1) whether ERISA applies to the case at bar, thus requiring the application of ERISA's civil enforcement provisions and thereby preempting plaintiffs' claim for penalties and mandatory attorney's fees under La. R.S. 22:657;
>
> 2) if ERISA applies, are plaintiffs precluded from having a jury trial;
>
> 3) If ERISA applies, should the evidence at trial be limited to that before defendant at the time of its final claims decision, thus precluding a *de novo* trial court review and requiring application of an arbitrary and capricious standard of review to the claims decision made by defendant?

After reviewing the case, the Court of Appeal ruled 1) ERISA applies to the case at bar because an "employee benefit plan," as the term is defined in ERISA, existed at the time the plaintiffs' claims arose; 2) plaintiffs' claim for penalties and mandatory attorney's fees is not preempted by ERISA; 3) plaintiffs are entitled to a jury trial of those issues pertaining to benefits under the Louisiana Insurance Code, but are not entitled to a jury trial of any

issue governed by ERISA; and 4) the evidence at trial should not be limited to that before the defendant at the time of its final claims decision, and the arbitrary and capricious standard is not applicable in the instant case.

Defendant applied to this Court for supervisory writs to challenge the rulings of the Court of Appeal. Specifically, defendant challenges 1) the Court of Appeal's ruling that ERISA does not preempt plaintiffs' state law claim for penalties and mandatory attorney's fees under La. R.S. 22:657; and 2) the Court of Appeal's ruling that plaintiffs are entitled to a jury trial of the claim under R.S. 22:657. Plaintiffs, in their response to defendant's arguments, do not challenge the Court of Appeal's ruling that ERISA applies to the instant case. Therefore, the primary issue before this Court is whether ERISA preempts La. R.S. 22:657. If La. R.S. 22:657 is preempted by ERISA, then plaintiffs have no cause of action for penalties and mandatory attorney's fees, and are not entitled to a jury trial.

I.

The Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001, et seq., is a comprehensive set of regulations governing employee pension and welfare plans. An employee welfare-benefit plan is defined in ERISA as one which provides to employees "medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability [or] death," whether these benefits are provided "through the purchase of insurance or otherwise." ERISA imposes upon pension plans a variety of substantive requirements relating to participation, funding, and vesting. 29 U.S.C. §§ 1051-1086. Additionally, ERISA establishes various uniform procedural standards concerning reporting, disclosure, and fiduciary responsibility for both pension and welfare plans.

To effectuate the substantive and procedural provisions of ERISA, Congress created within the Act an extensive civil enforcement scheme. 29 U.S.C. § 1132. Under the civil enforce-

ment provisions of ERISA, a plan participant or beneficiary may sue to recover benefits due under the plan, to enforce the participant's rights under the plan, or to clarify rights to future benefits. Relief may take the form of accrued benefits due, a declaratory judgment on entitlement to benefits, or an injunction against a plan administrator's improper refusal to pay benefits. Additionally, in an action under the civil enforcement provisions, the court in its discretion may allow an award of attorney's fees. *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987). However, the civil enforcement provisions do not allow exemplary damages. *Sommers Drug Stores Co. Employees Profit Sharing Trust v. Corrigan Enterprises, Inc.*, 793 F.2d 1456, 1464 (5th Cir. 1986), *cert. denied* 479 U.S. 1034, 107 S.Ct. 884, 93 L.Ed.2d 837, and 479 U.S. 1089, 107 S.Ct. 1298, 94 L.Ed.2d 154 (1987).

Recognizing that the broad provisions of ERISA overlap with numerous state regulatory laws, Congress put in ERISA three provisions relating to the preemptive effect of the federal legislation, often referred to as the pre-emption clause, the savings clause, and the deemer clause. The pre-emption clause[1] states:

> Except as other wise provided in subsection (b) of this section [the savings clause], the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan . . . *(Emphasis added)*

The savings clause[2] states:

> Except as provided in subparagraph (B) [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which *regulates insurance*, banking, or securities. *(Emphasis added.)*

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[1] 29 U.S.C. 1144(a).

[2] 29 U.S.C. 1144(b)(2)(A).

The deemer clause[3] states:

> Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . or to be engaged in the *business of insurance* . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts . . . *(Emphasis added.)*

As noted by the United States Supreme Court, the three pre-emption sections of ERISA are not a model of legislative drafting. *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 105 S.Ct.2380, 85 L.Ed.2d 728 (1985).[4] However, the sections generally can be said to work as follows: if a state law relates to employee benefit plans it is preempted unless the law "regulates insurance," in which case the savings clause saves the law from pre-emption; but, a state law that purports to regulate insurance may not deem an employee benefit plan to be an insurance company.

In this case, plaintiffs seek punitive damages and attorney's fees for defendant's alleged arbitrary and capricious failure to pay medical benefits under an employee welfare benefit plan. Plaintiffs rely on La. R.S. 22:657 for the recovery of such damages. R.S. 22:657 provides, in pertinent part:

> All claims arising under the terms of health and accident contracts issued in this state . . . shall be paid not more than thirty days from the date upon which written notice and proof of claim . . . are furnished to the insurer

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[3] 29 U.S.C. 1144(b)(2)(B).

[4] The court noted that the apparent clarity of the preemption sections on their faces is deceiving. The court stated, ". . . while the general preemption clause broadly preempts state law, the saving clause appears broadly to preserve the States' lawmaking power over much of the same regulation. While Congress occasionally decides to return to the States what it has previously taken away, it does not normally do both at the same time." 105 S.Ct at 2389.

> unless just and reasonable grounds . . . exist. Failure to comply with the provisions of this Section shall subject the insurer to a penalty payable to the insured of double the amount of the health and accident benefits due under the terms of the policy or contract during the period of delay, together with attorney's fees to be determined by the court.

The above-cited portion of §657 provides for mandatory attorney's fees and penalties in cases where an insurance company arbitrarily fails to pay benefits. As noted above, however, the ERISA civil enforcement provisions do not allow punitive damages for the arbitrary failure to pay employee welfare benefits, and attorney's fees in such actions are discretionary not mandatory. Thus, a concern in resolving the issue in the present case is whether La. R.S. 22:657 is a law which "regulates insurance" within the meaning of the savings clause such that the provision is not preempted by ERISA.

In interpreting the pre-emption clauses of ERISA, we have the benefit of two United States Supreme Court cases which clarify their scope and meaning. In *Pilot Life Insurance Co.v. Dedeaux*, supra, the Court held to be preempted by ERISA state common law tort and breach of contract actions asserting improper processing of a claim for benefits under an employee benefit plan. In *Metropolitan Life Insurance Co.v. Massachusetts*, supra, the court found a Massachusetts minimum health-care benefits law not to be preempted by ERISA. A careful reading of these two cases reveals the proper analysis to be used in determining whether a specific state law is preempted by ERISA.

First, we must determine if the state law at issue "relates to" an employee benefit plan such that it is within ERISA's pre-emption clause. In *Pilot Life*, the court noted that the phrase "relate[s] to" should be given its broad, common-sense interpretation. Thus, the court held, a state law "relates to" a benefit plan if it "has a connection with or reference to such a plan." It is not necessary for the law to be specifically designed to affect employee benefit plans. 105 S.Ct. at 2389. The court applied the common-sense test to the

cause of action raising improper handling of a claim for benefits under an employee benefit plan, and found the state law "undoubtedly meet[s] the criteria for pre-emption" under the pre-emption clause. 107 S.Ct. at 1553.

Applying the common-sense test to R.S. 22:657, it is clear the statute "relates to" an employee benefit plan. The basis for the plaintiff's suit is the defendant-insurer's alleged arbitrary and capricious failure to pay benefits under an employee benefit plan. R.S. 22:657 is specifically directed to an insurance company's handling of a claim under such an employee benefit plan.

Having found R.S. 22:657 "relates to" an employee benefit plan, we next determine if the statute "regulates insurance" and thus comes within the savings clause. To make this determination, we again turn to *Pilot Life*. In *Pilot Life*, the Supreme Court found Mississippi's common law of bad faith was preempted as it applied to a plaintiff's claim for the improper handling of an employee benefit plan. The Court first noted Mississippi's common law of bad faith was not specifically directed at insurance companies, but rather was a law of general application. Thus, the law did not fit the common sense meaning of the phrase "regulates insurance." However, the Court did not rest its holding solely on the common sense interpretation of the phrase. Instead, the Court sought guidance from federal jurisprudence interpreting the phrase "business of insurance" as used in the McCarran-Ferguson Act,[5] and from the role of the saving clause within the entire structure of ERISA.

A.

Three criteria have been used to determine whether a particular practice falls under "the business of insurance" for purposes of the McCarran-Ferguson Act. First, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether

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[5] The McCarran-Ferguson Act provides, in pertinent part: "[t]he business of insurance, and every person engaged therein, shall be subject of the laws of the several States which relate to the regulation or taxation of such business." 15 U.S.C. 1012 (a).

the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry. 107 S.Ct. at 1553. As applied to Mississippi's common law of bad faith, the court found that none of the factors was met. The common law of bad faith does not effect a spreading of policyholder risk. Further, although the common law of bad faith may be said to concern the policy relationship between the insured and the insurer, the connection to such relationship is tenuous. The law of bad faith does not define the substance of the relationship, but merely provides for a remedy when there has been a breach of the contract defining the relationship. Lastly, the court noted Mississippi's common law of bad faith is a law of general application not limited to entities in the insurance industry.

Applying the McCarran-Ferguson criteria to the facts of this case reveals much of what the Court in *Pilot Life* said about Mississippi's common law of bad faith applies to R.S. 22:657. Although § 657 is limited to insurance companies and thus meets the third factor of the McCarran-Ferguson test, factors one and two are not met. The statute is not an integral part of the insurer-insured relationship. The insurer-insured relationship is defined in the substantive provisions of the insurance contract, and consists of the respective obligations of each party to the contract. Just like the common law of bad faith found by the Supreme Court in *Pilot Life* not to be integral to the insurer-insured relationship, R.S. 22:657 merely provides a remedy, albeit statutory, for an insurance company's breach of a previously defined substantive relationship. Instead of regulating the substantive terms or content of insurance policies, R.S. 22:657 is primarily aimed at the procedural aspect of processing and settling claims.

Also, the statute does not effect a spreading of policyholder risk. As we appreciate the use of the term "spreading of risk" in the context of an insurance policy, the risk focused upon is that risk for which the insurance company has specifically contracted to reimburse its insured. In *Union Labor Life Ins. Co v. Pireno*, 458 U.S. 119, 102 S.Ct. 3002, 73 L.Ed.2d 647 (1982), the Supreme Court interpreted the phrase "spreading of policyholder risk" in the

context of the McCarran-Ferguson Act. The court stated, "[t]he transfer of risk from insured to insurer is effected by means of the contract between the parties — the insurance policy — and that transfer is complete at the time the contract is entered." 458 U.S. at 130. The court went on to note, ". . . the fundamental principle of insurance [is] that the insurance policy defines the scope of risk assumed by the insurer from the insured." 458 U.S. at 131. Thus, when looking to see if a particular practice acts to "spread the risk," we must focus upon the actual risks that were transferred from the insured to the insurer and determine if the practice acts to alter the contractual apportionment of those risks.

In this case, the Court of Appeal found, and plaintiffs argue, R.S. 22:657 meets the first factor of the McCarran-Ferguson factors because it acts to spread the risk that an insurer will improperly handle a settlement claim. However, the Court of Appeal's reasoning misconstrues the proper focus of the phrase "spreading a policyholder's risk." The employee benefit plan in question pertains to health insurance. In a health insurance contract, the risk spread among policyholders is the risk that an insured will require medical care for a covered illness. The insurance contract does not seek to spread the risk that the insurer will improperly handle a settlement claim. In fact, if the Court of Appeal's reasoning were correct, the Supreme Court in *Pilot Life* would have found the Mississippi law in question to be a practice which acts to spread a policyholder's risk when applied in the context of an employee benefit plan. To the contrary, however, the Supreme Court found Mississippi's law did not have such an effect, and this Court can discern no principled reason why the same conclusion is not warranted in this case. The mere fact that R.S. 22:657 is a statutory remedy while the law in *Pilot Life* was a common law remedy is a distinction without relevance to the issue of whether R.S. 22:657 acts to spread a policyholder's risk.

B.

Our finding that R.S. 22:657 fails to meet two of the three McCarran-Ferguson criteria does not necessarily end our analysis. As the Court in *Pilot Life* indicated, the McCarran-Ferguson test is

not the sole consideration to be addressed in determining whether a particular state law is preempted by ERISA. A reviewing court should also consider the role of the saving clause in ERISA as a whole to determine if application of the state law in question would interfere with the goals sought to be achieved by ERISA. In *Pilot Life*, the court referred to the comprehensive civil enforcement scheme of ERISA, and noted it is one of the essential tools for accomplishing the stated purposes of the Act. The court went on to hold Congress clearly expressed an intent that the civil enforcement provisions of ERISA be the *exclusive* vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits. The court stated, "[t]he policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." 107 S.Ct. at 1556.

In this case, plaintiffs, ERISA-plan participants, are seeking to use R.S. 22:657 as a vehicle to obtain relief for the alleged improper handling of their claim for benefits. As noted previously, R.S. 22:657 allows punitive damages to be recovered for an insurer's arbitrary refusal to pay benefits, and mandates the payment of attorney's fees. The civil enforcement scheme of ERISA does not allow punitive damages and attorney's fees are discretionary not mandatory. *Pilot Life*, supra. Thus, there is a clear conflict between R.S. 22:657 and the substantive provisions of ERISA's civil enforcement scheme. Consequently, the clear language used by the Supreme Court in *Pilot Life* compels us to hold that R.S.22:657, as applied to an ERISA plan, is preempted by the civil enforcement provisions of ERISA.

In finding R.S. 22:657 not to be preempted, the Court of Appeal stated, "[t]o hold otherwise would violate the most fundamental of all substantial policies of ERISA, viz. to protect the interest of the employee." *Cramer v. Association Life Ins. Co., Inc.*, 563 So.2d 267, 275 (La. App. 1st Cir. 1990). This statement overlooks the fact that Congress created a comprehensive civil enforcement scheme

designed specifically to protect the interests of the employee. Under 29 U.S.C. § 1132, plaintiffs have a cause of action against defendant for the recovery of accrued benefits due, and may recover reasonable attorney's fees if the trial court determines the facts warrant such an award. Merely because Congress chose not to adopt the type of remedy available in R.S. 22:657 does not mean employees' interests are not being protected adequately. Indeed, as the court in *Pilot Life* noted, the civil enforcement provisions in ERISA represent a "careful balancing of the need for prompt and fair claims settlement procedures and the public interest in encouraging the formation of employee benefit plans." 107 S.Ct. at 1556. To disrupt Congress' carefully thought-out remedies by allowing plaintiffs to raise a claim under R.S. 22:657 would be to ignore the strong evidence that Congress intended ERISA's civil remedies to be exclusive.

Our holding in this case is supported by the vast majority of the federal jurisprudence interpreting statutes similar to R.S. 22:657. In *Ramirez v. Inter-Continental Hotels*, 890 F.2d 760 (5th Cir. 1989), the court held that Texas Insurance Code article 21.21 § 16 was preempted by ERISA. The Texas statute furnishes a right of action and allows treble damages and attorneys' fees to persons injured by certain enumerated unfair methods of competition and unfair and deceptive acts or practices in the business of insurance. Plaintiff attempted to use the statute to recover punitive damages for the insurer's failure to pay benefits allegedly due plaintiff. Referring to the McCarran-Ferguson factors mentioned in *Pilot Life*, the court found the statute does not transfer or spread policyholder risk, and does not define the terms of the relationship between the insurer and the insured. Additionally, the court found the effect of the statute to be indistinguishable from the effect of the common law addressed in Pilot Life. The court stated, "[t]o interpret the savings clause as authorizing such inconsistent state remedies would be to defeat Congressional intent by destroying the exclusivity of ERISA's civil enforcement provisions." 890 F.2d at 763-64. *See also, Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988), *cert. denied*, —U.S.—, 109 S.Ct. 3216,

106 L.Ed.2d. 566 (1989) (California statute prohibiting unfair insurance claims processing held preempted by ERISA); *In Re Life Ins. Co. of N.Am.*, 857 F.2d 1190 (8th Cir. 1988) (Missouri statute prohibiting vexatious refusal to pay insurance claims held preempted by ERISA); *Anschultz v. Connecticut Gen. Life Ins. Co.*, 850 F.2d 1467 (11th Cir. 1988) (Florida statute providing private right of action to persons injured by violations of state's insurance code held preempted by ERISA).

Particularly persuasive is the unanimity of the Louisiana federal district courts in holding R.S. 22:657 to be preempted by ERISA.[6] In each of these cases, the court has found R.S. 22:657 to be in conflict with the comprehensive civil enforcement provisions of ERISA. The Court of Appeal in the instant case felt the lower federal court holdings were not persuasive because each was rendered prior to this Court's ruling in *Soniat v. Travelers Ins. Co.*, 538 So.2d 210 (La. 1989). However, *Soniat* deals with a statute which is clearly distinguishable from R.S. 22:657.

In *Soniat*, this Court considered whether La. R.S. 22:213(B)(7)[7] was preempted by ERISA. Specifically, we considered whether ERISA preempts the portion of § 213 which prevents the cancellation of a policy from prejudicing the rights of a policyholder concerning claims arising prior to the cancellation. In finding R.S. 22:213 to be within the savings clause of ERISA and thus not preempted, we reviewed the McCarran-Ferguson factors and found they were met. More importantly, however, we noted

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[6] *Taylor v. Blue Cross/Blue Shield of New York*, 684 F.Supp 1352 (E.D. La. 1988); *Sublett v. Premier Bancorp Self Funded Medical Plan*. 683 F.Supp 153 (M.D. La. 1988); *Rasmussen v. Metropolitan Life Ins. Co.*, 675 F.Supp 1497 (W.D. La. 1987).

[7] At the time of the events involved in *Soniat* took place, La. R.S. 22:213(B)(7) provided: "Cancellation: the insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to his last address as shown by the records of the insurer, and shall refund the pro rata unearned portion of any premium paid. *Such cancellation shall be without prejudice to any claim originating prior thereto . . .*" (Emphasis added.)

that R.S. 22:213(B)(7) "does not conflict with the substantive provisions of ERISA and . . . does not create a conflict with ERISA's civil enforcement scheme." 538 So.2d at 215.

Additionally, a careful reading of *Soniat* reveals the statute involved in that case is more closely analogous to the mandated-benefit law held by the court in *Metropolitan Life* not to be preempted by ERISA than it is to R.S. 22:657 or the common law of bad faith involved in *Pilot Life*. For the reasons discussed below, we believe the United States Supreme Court in *Metropolitan Life* and *Pilot Life* has created a distinction between state laws which regulate the substantive terms of the insurance contract, such as the statute involved in *Soniat*, and those which merely regulate aspects of transacting the business of group insurance, such as R.S. 22:657.

In *Metropolitan Life*, the Supreme Court addressed the question of whether Massachusetts Gen.Laws Ann., ch. 175 §47B (West Supp. 1985) is preempted by ERISA. The statute requires any general health-insurance policy issued to a Massachusetts resident that provides hospital and surgical coverage, or any benefit plan that has such coverage, to provide as well a certain minimum of mental-health protection. The Court held the statute "regulates insurance" and thus is not preempted by ERISA. Of particular importance is the Court's discussion of the various types of state insurance regulation that exist, and the reason why §47B was not the type of state regulation intended to be preempted by ERISA. The Court noted state insurance regulations can be categorized as follows: regulation of the insurance carrier, regulation of the aspects of transacting the business of group insurance, and regulation of the content of the insurance contracts. As an example of the kinds of state laws which regulate the content of the insurance contract, the Court mentioned those requiring policies to contain grace periods and conversion privileges. The Court also construed mandated-benefit regulations, like §47B, to fall within the regulation of the content of the insurance contract.

After categorizing §47B as a type of law regulating the content of the insurance contract, the Court noted that ERISA "does not regulate the substantive content of welfare-benefit plans." 105

S.Ct. at 2385. The Court then found §47B not to be preempted by ERISA, and made the following observations which illuminate the rationale both for the holding in *Metropolitan Life* and the later holding in *Pilot Life:*

> To state the obvious, §47B regulates the terms of certain insurance contracts, and so seems to be saved from preemption by the saving clause as a law 'which regulates insurance.' This common-sense view of the matter, moreover, is reinforced by the language of the subsequent subsection of ERISA, the 'deemer clause' which states that an employee-benefit plan shall not be deemed to be an insurance company 'for purposes of any law of any State purporting to regulate insurance companies, *insurance contracts,* banks, trust companies, or investment companies.' (emphasis added) By exempting from the saving clause laws regulation insurance contracts that apply directly to benefit plans, the deemer clause makes explicit Congress' intention to include laws that regulate insurance contracts within the scope of the insurance laws preserved by the saving clause.

105 S.Ct. at 2389-90. When the quoted language is considered in light of the Court's earlier categorization of the types of state insurance regulation, it is clear the Court in *Metropolitan Life* was restricting its holding to those state laws which regulate the contents of the insurance contract. In other words, the Court's holding does not address those types of state laws which regulate the carrier or which regulate aspects of transacting the business of group insurance.

The precise scope of the holding in *Metropolitan Life* is mentioned because it is important to a complete understanding of the rationale used by the Supreme Court in *Pilot Life*. In *Pilot Life*, the Mississippi law focused upon, when applied to an employee-benefit plan, did not fall within the category of laws which regulate the content of the insurance contract. Rather, the law, when applied to an employee-benefit plan, more appropriately fit within the *Metropolitan Life* Court's second category of laws regulating insur-

ance, namely one which regulates aspects of transacting the business of insurance.[8] Consequently, the Court in *Pilot Life* had to address a law which, unlike the law in *Metropolitan Life*, governed matters also governed by ERISA. By finding the Mississippi law to be preempted because of its conflict with ERISA's civil enforcement scheme, the Court in *Pilot Life* essentially created a distinction between state laws which regulate the content of the insurance contract, such as mandated benefit laws, and state laws which regulate aspects of transacting the business of insurance, such as remedial laws pertaining to claims handling. State laws which fall into the latter category are preempted by ERISA because ERISA itself contains a comprehensive civil enforcement scheme which regulates the practice of claims handling. State laws which fall into the former category are not preempted because ERISA itself contains no regulation of the substantive terms of insurance contracts.

With the above distinction in mind, it is clear our holding in *Soniat* does not conflict with our holding today. The statute involved in *Soniat*, by preventing the cancellation of a policy from prejudicing the rights of a policyholder concerning claims arising prior to the cancellation, regulates the substantive terms of any health insurance contract issued in Louisiana. It essentially redefines a "covered" illness for purposes of the insurance contract. Thus, the statute falls within the same category of regulations as was involved in *Metropolitan Life*. R.S. 22:657, on the other hand, has no effect on the substantive terms of the insurance contract. It merely grants a remedy for the breach of a previously defined contractual relationship. Thus, it falls within the category of regulations which regulate aspects of transacting the business of insurance, which are preempted by ERISA.

II.

Because we find La. R.S. 22:657 is preempted by ERISA, it follows that plaintiffs are not entitled to a trial by jury. The Court of Appeal's ruling indicates the only state law claims raised by

[8] In fact, as an example of a law which regulates aspects of transacting the business of insurance, the Court in *Metropolitan Life* referred to laws regulating claims practices. 105 S.Ct. at 2383, n. 2.

plaintiffs are those arising under R.S. 22:657. Because the R.S. 22:657 claims are preempted, plaintiffs' only remaining claims arise under ERISA. Federal law is clear that no right to a trial by jury exists under ERISA on an action to recover benefits, or to clarify or enforce rights under an employee welfare benefit plan. *Crews v. Central States, Southeast and Southwest Areas Pension Fund*, 788 F.2d 332, 338 (5th Cir. 1986); *Howard v. Parisian, Inc.*, 807 F.2d 1560, 1567 (11th Cir. 1987).

CONCLUSION

We hold La. R.S. 22:657, as applied to a claim under an employee welfare benefit plan subject to ERISA, is preempted by ERISA both because it fails to meet the McCarran-Ferguson criteria and because it conflicts with the civil enforcement provisions of ERISA. The Court of Appeal's denial of defendant's motion for partial summary judgment is reversed and the case is remanded to the trial court for further proceedings in accordance with our ruling.

REVERSED AND REMANDED.

CALOGERO, C.J., Dissenting.

I dissent from the majority's conclusion that La. R.S. 22:657, providing for penalties and attorney's fees to be paid by an insurer who unjustly delays the payment of a claim, is preempted by ERISA. This statute regulates insurance, and therefore ERISA's "saving clause" excepts the statute from preemption.

The majority relies on the United States Supreme Court's decision in *Pilot Life* in finding that R.S. 22:657 does not fall within the saving clause. In *Pilot Life*, the United States Supreme Court weighed two major considerations which guided it in *Metropolitan*

Life in determining whether a state law comes under the saving clause. These were: 1) a "common sense view" of the language of the clause itself, and 2) the criteria used to interpret the term "business of insurance" for purposes of the McCarran-Ferguson Act. *Pilot Life*, 481 U.S. at 48, 107 S.Ct. at 1553, 95 L.Ed.2d at 48.

Under the common sense test, La. R.S. 22:657 clearly falls within the saving clause. In allowing for attorney's fees and penalties to be assessed against an insurer who unjustly fails to pay a claim within thirty days, the statute is directed at regulating the duties of an insurer in any health and accident contract. La. R.S. 22:657 therefore regulates the "business of insurance" and passes the common sense test. In *Pilot Life*, the court found that the Mississippi common law of bad faith was not saved under a common sense view because the law was not directed specifically toward the insurance industry, but was firmly planted in principles of tort and contract law. The statute in question here is clearly directed toward the insurance industry and should be found to fall under the language of the saving clause.

As for the second consideration employed in *Pilot Life*, I find that two of the three McCarran-Ferguson criteria have been met. I agree with the majority that this statute does not have the effect of spreading the policyholder's risk and that the first criterion has not been met. However, I disagree with the majority's finding that the statute is not an integral part of the insurer-insured relationship. Timely payment of a claim is the central obligation of an insurance contract and a matter of major importance in the relationship between the parties to that contract. This statute imposes a duty on the insurer to pay a claim within a certain time and establishes a penalty for breaching that obligation. The statute affects an integral part of the relationship and meets the second McCarran-Ferguson factor. As to the third factor, even the majority concedes, and I agree, that the statute is directed toward entities within the insurance industry.

No one of the McCarran-Ferguson criteria is determinative, and therefore not all three are necessary to find a statute to regulate the business of insurance. *Pireno*, 458 U.S. at 129, 102 S.Ct. at 3009,

73 L.Ed.2d at 657. Two of the three McCarran-Ferguson factors are met. I find that this, along with the fact that the statute passes the common sense test of regulating the business of insurance, establishes that La. R.S. 22:657 falls under the saving clause and is not preempted by ERISA.

It should also be noted that the primary basis for our finding in *Soniat* that La. R.S. 22:213 B(7) was not preempted was the fact that it is part of the Insurance Code, whose stated purpose is to "regulate insurers and the insurance business." *Soniat*, 538 So.2d at 214. The statute in question here is also part of that body of law and should be considered to regulate insurance and fall under the saving clause.

In conclusion, while ERISA does apply to this case because it deals with an "employee benefit plan," a state law cause of action still exists because La. R.S. 22:657 is not preempted by ERISA. The plaintiff therefore should have a claim for penalties and attorney's fees and should be allowed a jury trial on these issues. I would affirm the Court of Appeal's decision.

APPENDIX C

CHARLES R. CRAMER, JR. AND
NEVA GAGE CRAMER
v.
ASSOCIATION LIFE INSURANCE COMPANY, INC.

No. 306, 871, Div. "M"

19th Judicial District Court,
Parish of East Baton Rouge
State of Louisiana

FIRST AMENDED AND SUPPLEMENTAL ANSWER

NOW INTO COURT, through undersigned counsel, comes Association Life Insurance Company Inc. ("Association Life"), who desires to amend and supplement its original answer as follows:

1.

To amend the following numbered paragraph of its answer to state as follows:

"X.

Responding to paragraph 23 of the petition, Association Life states that plaintiffs are not entitled to a trial by jury because the claims asserted in plaintiffs' petition are preempted by 29 U.S.C. 1132, *et seq.*, which precludes a trial by jury for claims encompassed by the Employee Retirement Income Security Act ("ERISA")."

2.

To add the following numbered paragraphs to its answer:

"XIII.

Association Life affirmatively pleads that plaintiffs do not have a cause of action for penalties or attorneys' fees under La. R.S. 22:657 because La. 22:657 is preempted by the civil enforcement penalties provided in 29 U.S.C. 1132, which precludes the penalties and mandatory attorneys' fees called for in La. R.S. 22:657.

XIV.

Further answering, Association Life states that it complied with the statutory requirements of ERISA in the processing of the plaintiffs' claims.

XV.

This Court is prohibited from conducting a *de novo* review of this matter and must uphold the denial of benefits by Association Life, whose conduct in denying benefits was not arbitrary or capricious."

WHEREFORE, Association Life Insurance Company Inc. prays that its answer be amended and supplemented as stated above and reiterates the responses contained in its original answer, praying that plaintiffs' petition be dismissed, with prejudice, at the costs of plaintiffs.

By Attorneys:

BREAZEALE, SACHSE & WILSON
One American Place, 23rd Floor
Post Office Box 3197
Baton Rouge, Louisiana 70821-3197
Telephone: (504) 387-4000

/s/ Christine Lipsey

ORDER

Considering the foregoing First Amended and Supplemental Answer:

IT IS ORDERED that the First Amended and Supplemental Answer filed by Association Life Insurance Company Inc. be allowed as prayed for.

Baton Rouge, Louisiana, this _____ day of November, 1988.

_____

Judge, 19th Judicial District Court

CERTIFICATE OF MAILING

I hereby certify that a copy of the above and foregoing First Amended and Supplemental Answer has been mailed to Mr. Allen M. Posey, Jr., Attorney for Plaintiffs, 4920 Jamestown Avenue, Post Office Drawer 14879, Baton Rouge, Louisiana, 70898, by First Class United States Mail, properly addressed and postage prepaid on the 7th day of November, 1988.

/s/ Christine Lipsey

APPENDIX D

CHARLES R. CRAMER, JR. AND
NEVA GAGE CRAMER
v.
ASSOCIATION LIFE INSURANCE COMPANY, INC.

Number: 306,871, Div. "M"

19th Judicial District Court
Parish of East Baton Rouge
State of Louisiana

EXCEPTION OF NO CAUSE OF ACTION, OR ALTERNATIVELY, MOTION FOR PARTIAL SUMMARY JUDGMENT

NOW INTO COURT, through undersigned counsel, comes Association Life Insurance Company Inc. ("Association Life"), who, on the basis of The Employment Retirement Security Income Act of 1974, as amended, 29 U.S.C. §§ 1001, *et seq.* ("ERISA"), alleges that plaintiffs' state law claims for breach of contract and penalties and attorneys' fees under La. R.S. 22:657 are preempted and displaced by ERISA's civil enforcement remedies contained in 29 U.S.C. § 1132, which remedies do not include punitive damages and mandatory attorneys' fees. Plaintiffs, therefore, have no cause of action for the penalties and mandatory attorneys' fees allowed by La. R.S. 22:657.

In support of its exception/motion, Association Life attaches hereto as Exhibit 1 a certified copy of the petition filed in this matter. Attached hereto as Exhibit 2 is a certified copy of Associa-

tion Life's response to plaintiffs' second set of interrogatories and request for production of documents, with attachments. A memorandum in support also accompanies this exception/motion.

WHEREFORE, Association Life Insurance Company Inc. prays that the Court grant its exception of no cause of action to plaintiffs' claim under La. R.S. 22:657 for penalties and mandatory attorneys' fees. Alternatively, Association Life Insurance Company Inc. moves for partial summary judgment on plaintiffs' claim for penalties and mandatory attorneys' fees under La. R.S. 22:657.

By Attorneys:

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Post Office Box 3197
Baton Rouge, Louisiana 70821-3197
Telephone: (504) 387-4000

/s/ Christine Lipsey
Attorneys for Association Life
Insurance Company Inc.

Please Serve:

Charles R. Cramer, Jr. and Neva Gage Cramer
through their attorney of record
Mr. Allen M. Posey, Jr.
4920 Jamestown Avenue
Baton Rouge, Louisiana 70898-4879

ORDER

Considering the foregoing exception of no cause of action, or alternatively, motion for partial summary judgment, Charles R. Cramer, Jr. and Neva Gage Cramer are hereby ordered to show cause on the 6th day of January at 9:30 a.m. why Association Life Insurance Company Inc.'s exception of no cause of action or, alternatively, motion for partial summary judgment should not be granted.

Baton Rouge, Louisiana, this 15th day of December, 1988.

/s/ Joseph F. Keogh
Judge, 19th Judicial District Court

APPENDIX E

CHARLES R. CRAMER, JR. AND
NEVA GAGE CRAMER
v.
ASSOCIATION LIFE INSURANCE COMPANY, INC.

Number: 305, 871 Division: "M"

19th Judicial District Court
Parish of East Baton Rouge
State of Louisiana

MOTION FOR PARTIAL SUMMARY JUDGMENT

NOW INTO COURT, through undersigned counsel, come plaintiffs, Charles R. Cramer, Jr. and Neva Gage Cramer who move this court to rule that as a matter of law plaintiffs' claim for health insurance benefits and for penalties and attorney's fees is not subject to preemption by the Employment Retirement Security Income Act of 1974, as amended, 29 U.S.C. §1001, *et seq.* .

In support of this Motion, and also in opposition to defendant's Motion for Summary Judgment, plaintiffs attach hereto as exhibit 1, the affidavit of Charles R. Cramer, Sr., the president, director and sole shareholder (with his wife) of plaintiff's employer, Advertising by Computer, Inc. Plaintiffs also attach as exhibit 2, Plaintiffs' Fourth Request for Admission and Request for Production of Documents and as exhibit 3, Association Life Insurance Company's Response to Plaintiffs' Fourth Request for Admission and Request for Production of Documents.

WHEREFORE, plaintiffs, Charles R. Cramer, Jr. and Neva Gage Cramer move for partial summary judgment on defendant's affirmative defense of ERISA preemption.

Respectfully submitted:

/s/ Allen M. Posey, Jr.

ALLEN M. POSEY, JR.
4920 Jamestown Avenue
Post Office Drawer 14879
Baton Rouge, Louisiana 70898
Telephone: 504/926-3120
Attorney for plaintiffs,
Charles R. Cramer, Jr. and
Neva Gage Cramer

INFORMATION FOR SERVICE:

Please withhold formal service on defendant at this time pending notification from counsel.

ORDER

Considering the foregoing Motion for Summary Judgment, Association Life Insurance Company, Inc., is hereby ordered to show cause on the 6th day of January, 1989, at 9:30 o'clock a.m. why plaintiffs' Motion for Partial Summary Judgment should not be granted.

Baton Rouge, Louisiana this _____ day of January, 1989.

/s/ Joseph F. Keogh
Judge, 19th Judicial District Court

CERTIFICATE OF SERVICE

I certify that a copy of above and foregoing has been served on counsel for all parties in these proceedings, by hand delivery on this 4th day of January, 1989.

/s/ Allen M. Posey, Jr.

CHARLES R. CRAMER, JR. AND
NEVA GAGE CRAMER
v.
ASSOCIATION LIFE INSURANCE COMPANY, INC.

Number: 305, 871, Division: "M"

19th Judicial District Court
Parish of East Baton Rouge
State of Louisiana

AFFIDAVIT OF CHARLES R. CRAMER, SR.

BEFORE ME, THE UNDERSIGNED NOTARY PUBLIC, duly commissioned and qualified in and for the state aforesaid, personally came and appeared:

CHARLES R. CRAMER, SR. who, after being duly sworn did depose and state that:

1. That he is the founder and incorporator of Advertising by Computer, Inc. (ABC) and was the president, director and together with his wife, the sole shareholder of ABC;

2. That ABC from August 1, 1985, through the first part of 1986 was the employer of his son, Charles R. Cramer, Jr.

3. That ABC purchased a group health insurance policy from Association Life Insurance Company, Inc., bearing group policy #11709;

4. That ABC had no plan for providing employee welfare benefits to its employees; that no such plan was ever contemplated by ABC or discussed at any meeting of the shareholder, officers or directors;

5. That it simply purchased a group health insurance policy from Association Life Insurance Company, Inc.;

6. That ABC had no intent to continuously provide health insurance benefits and that if any health insurance policy became too expensive or did not pay benefits as expected, such policy would have simply been canceled;

7. That, in fact, the policy with Association Life Insurance Company, was, in fact, canceled in approximately December of 1985 because of Association Life's failure to pay claims under that policy and that no replacement policy was purchased for the employees of ABC.

8. Prior to 1988, affiant had not heard of the Employee Retirement Income Security Act of 1974 or heard of any federal statute called "ERISA;"

9. That until his discussions with Allen M. Posey, Jr., attorney-at-law, in January of 1989 and with Charles R. Cramer, Jr., in December of 1988, affiant had no idea that there was any possibility that ABC or any of its officers or directors might fall under the provisions of the federal act called ERISA;

10. That ABC had no employee welfare benefit plan, written or otherwise;

11. That ABC filed no plan or description or summary of any plan with the Secretary of the Department of Labor and furnished no such plan or plan summary or description to its employees;

12. That therefore, no annual statement of any plan was ever prepared;

13. That attorney, Allen M. Posey, Jr., has shown to him the provisions of subparagraph (e) of 29 U.S.C. 1023, that he has read that paragraph and that Association Life Insurance Company did not provide to ABC the statement referred to in that subparagraph (e);

14. That ABC simply purchased a group health insurance policy for its employees — nothing more.

/s/ Charles R. Cramer, Sr.

SWORN TO AND SUBSCRIBED before me, this 4th day of January, 1989, at Baton Rouge, Louisiana.

/s/Allen M. Posey, Jr.
Notary Public

APPENDIX F

CHARLES R. CRAMER, JR. AND
NEVA GAGE CRAMER
v.
ASSOCIATION LIFE INSURANCE COMPANY, INC.

Number: 306 (SIC), 871 Div. "M"

19th Judicial District Court
Parish of East Baton Rouge
State of Louisiana

JUDGMENT

This cause came on for hearing on defendant's motion to amend pretrial order, motion in limine, and exception of no cause of action, or alternatively, motion for partial summary judgment, pursuant to regular assignment and after notice. Also considered was plaintiffs' cross motion for partial summary judgment. Present in court were Christine Lipsey for Association Life Insurance Company and Allen M. Posey, Jr. for Charles R. Cramer, Jr. and Neva Gage Cramer.

The Court, after reviewing the memoranda and supporting documents and considering the law applicable to the motions, rendered the following decree:

IT IS ORDERED, ADJUDGED AND DECREED that defendant's motion to amend pretrial order is granted, defendant's motion in limine is denied, and defendant's exception of no cause of action, or alternatively, motion for partial summary judgment is denied. Plaintiffs' cross motion for partial summary judgment is granted.

Judgment rendered on the 6th day of January, 1989.

Judgment read and signed in Chambers in Baton Rouge, Louisiana, this 9th day of January, 1989.

/s/ Joseph F. Keogh
Judge, 19th Judicial District Court

RESPECTFULLY SUBMITTED:

BREAZEALE, SACHSE & WILSON
One American Place, 23rd Floor
Post Office Box 3197
Baton Rouge, Louisiana 70821-3197
Telephone: (504) 387-4000

/s/ Christine Lipsey
Attorneys for Association Life
Insurance Company Inc.

CERTIFICATE OF MAILING

I hereby certify that a copy of the above and foregoing Judgment has been mailed to Mr. Allen M. Posey, Jr., Attorney for Plantiffs, 4920 Jamestown Avenue, Baton Rouge, Louisiana 70802, by First Class United States Mail, properly addressed and postage prepaid on the 9th day of January, 1989.

/s/ Christine Lipsey

APPENDIX G

La. R.S. 22:2 A. (1) (in pertinent part):

Insurance is a business affected with the public interest and it is the purpose of this Code to regulate that business in all its phases . . . .

La. R.S. 22:657

All claims arising under the terms of health and accident contracts issued in this state, except as provided in Subsection B, shall be paid not more than thirty days from the date upon which written notice and proof of claim, in the form required by the terms of the policy, are furnished to the insurer unless just and reasonable grounds, such as would put a reasonable and prudent business man on his guard, exist. The insurer shall make payment at least every thirty days to the assured during that part of the period of his disability covered by the policy or contract of insurance during which the insured is entitled to such payments. Failure to comply with the provisions of this Section shall subject the insurer to a penalty payable to the insured of double the amount of the health and accident benefits due under the terms of the policy or contract during the period of delay, together with attorney's fees to be determined by the court. The district court of the parish where the insured lives or has his domicile shall have jurisdiction to try such cases.

29 U.S.C. 1144(a) (preemption clause)

"Except as provided in subsection (b) of this section [the saving clause], the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ."

29 U.S.C. 1144(b)(2)(A) (saving clause)

"Except as provided in subparagraph (B) [the deemer clause], nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."

29 U.S.C. 1144(b)(2)(B) (deemer clause)

"Neither an employee benefit plan... nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies."

15 U.S.C. 1011 Declaration of Policy

The Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

15 U.S.C. 1012 Regulation by State law; Federal law relating specifically to insurance; applicability of certain Federal laws after June 30, 1948.

(a) State regulation. The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) Federal regulation. No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance . . . .

APPENDIX H

Volume XXIII Number 9

CBS NEWS

524 West 75th Street, New York, NY 10019

60 Minutes
With CBS News Correspondents
Mike Wallace, Morley Safer, Ed Bradley

"I THOUGHT I WAS COVERED"

Produced by David Gelber
November 11, 1990

BRADLEY: With 37 million Americans lacking any health insurance at all, the 180 million who are covered by private insurance companies have every reason to feel they're the lucky ones, but more and more Americans who think they're the lucky ones — think they're fully covered — are finding out they're not and finding it out at the worst possible time.

[voice-over] California Congressman Howard Berman monitors the insurance industry on the House Judiciary Committee.

HOWARD L. BERMAN, (D-CA), California, House Judiciary Committee: We are getting a tremendous increase in the number of complaints from people about arbitrary cancellations, illegal refusal to pay health claims, hospital bills, doctors' bills.

BRADLEY: Berman says one reason for the increase is a recent Supreme Court decision which ruled that people who belong to group health-insurance plans can't sue insurance companies for financial loss, pain and suffering or punitive damages. All they can get in a lawsuit is the actual cost of their medical expenses.

Rep. BERMAN: The effect of the Supreme Court decision was to eliminate any penalty, any deterrent on an insurance company's conduct.

BRADLEY: *[voice-over]* Take the case of Steve Spain a 42-year-old father with advanced cancer. Spain's doctors at the UCLA Medical Center decided his only chance to beat cancer was a three-stage bone-marrow-transplant procedure costing about $150,000, which his insurance company agreed to pay for.

STEVE SPAIN, Cancer Patient: Basically, without the procedure, I had a not a very good chance at all and with the procedure, it looked like I had a pretty good chance of even being cured.

BRADLEY: *[voice-over]* Spain completed the first phase of the treatment, but just when he was about to reenter the hospital his insurance company, Aetna, notified UCLA it wouldn't pay for the procedure after all. Dr. Gary Schiller, Spain's doctor, is on the UCLA faculty.

[interviewing] Did Spain and UCLA have good reason to believe that Aetna would cover the procedure?

DR. GARY SCHILLER, M.D., University of California at Los Angeles Medical Center: Well, we have documentation, which I have here, that indicated that this procedure would be covered.

BRADLEY: No problems?

Dr. SCHILLER: Correct.

BRADLEY: Why did Aetna change its mind? Their letter to Spain said the company first thought he had one type of cancer which is approved for bone-marrow treatment and then later discovered he had another type of cancer which is not, but Aetna's representative who signed the letter didn't know what any doctor would have known: There is no difference at all between the two types of cancer.

Dr. SCHILLER: I thought it was crazy, but I thought that I could appeal to the medical person who was responsible for being consultant in the insurance company.

BRADLEY: Did you call them?

Dr. SCHILLER: So I called and I pursued this quite vigorously.

BRADLEY: *[voice-over]* Schiller says he called Aetna five or six times a day for several days to tell them about the mistake they'd made. Aetna sent us a letter claiming one of their doctors did talk to Schiller. Schiller says he didn't.

Dr. SCHILLER: I was able to speak only to the person who issued the initial correspondence. I never was allowed to speak to the medical consultant.

BRADLEY: And they know that you're on the faculty here at UCLA?

Dr. SCHILLER: Oh, yes.

BRADLEY: And you still couldn't get through?

Dr. SCHILLER: No, I could not get through.

BRADLEY: *[voice-over]* Finally, Dr. Schiller told Steve Spain he ought to hire a lawyer. Spain found Bill Shernoff, who's taken a number of cases like Spain's even though the recent Supreme Court

ruling makes it impossible to win a big-jury verdict. All Shernoff could win for Spain is the cost of his medical care, even if he could convince a jury that Aetna's treatment of Spain was outrageous.

[interviewing] Couldn't it have been an honest mistake that any big corporation could make?

BILL SHERNOFF, Steve Spain's Lawyer: If it was just a mistake, when somebody brought it to their attention, they would have rectified it. Well, the doctors brought it to attention several times and they ignored it, and it was only after we worked around the clock and ran into federal court to get an injunction did they finally call us.

BRADLEY: *[voice-over]* Aetna finally agreed to pay for the procedure, but they declined our repeated requests for an interview.

[on camera] Aetna did write us to say that their mistake was in authorizing the procedure in the first place. Since they did agree to pay in the end, the Aetna letter says the mistake was to Mr. Spain's financial benefit but during the delay, which Aetna caused, Dr. Schiller says Steve Spain's tumors began to grow again.

Dr. SCHILLER: For Mr. Spain, this may translate into a less effective treatment, but only time will tell.

BRADLEY: So the delay didn't help him —

Dr. SCHILLER: Certainly not.

BRADLEY: — and it could have hurt him.

Dr. SCHILLER: Yes.

BRADLEY: *[voice-over]* Larry Raicht is certain he's been hurt — and hurt badly — by his insurance company. Raicht, a former U.S. consul general stationed in Canada, has multiple sclerosis. He'll never be cured but his doctors say hydrotherapy will prolong the use of his arms and legs. His insurance company, Mutual of Omaha, paid for his hydrotherapy for one year, then in 1987, they abruptly canceled the treatment, claiming he wasn't getting better. Of course, the goal of the therapy all along was to keep him from getting worse. Raicht's physician is Dr. Bruce Becker.

[interviewing] So is what he was doing more than maintenance or is maintenance what he needs to do?

BRUCE BECKER, M.D., Physician of Larry Raicht's: Maintenance doesn't sound unreasonable to me in the face of a chronic, progressive disease, but he was actually achieving more than maintenance.

BRADLEY: You wrote to Mutual of Omaha expressing your medical opinion —

Dr. BECKER: I did.

BRADLEY: — and you heard nothing from them?

Dr. BECKER: There was never a response from them. I have no correspondence from Mutual of Omaha in the records at all.

BRADLEY: *[voice-over]* For two years, Mutual of Omaha refused to pay for Raicht's therapy. For the first year, his therapist let him run up a $9,000 bill. For the second year, he had no therapy at all. During that period, his arm and leg deteriorated at a much faster rate than before.

[interviewing] Would he have been better off today if he had continued therapy?

Dr. BECKER: I believe that to be true.

BRADLEY: *[voice-over]* As a former employee of the State Department, Larry Raicht had the right to appeal Mutual of Omaha's decision to the U.S. Government's Office of Personnel Management. The O.P.M. asked Mutual to send Raicht's complete file so it could conduct a fair review, but when Congressman Berman checked, he discovered that Mutual of Omaha sent its expert's opinion, but failed to send Dr. Becker's letter protesting their decision.

[interviewing] So they're looking, effectively, at one side of the case?

Rep. BERMAN: They have the insurance company's information or disinformation, as it were, without any information from the guy's own physician.

BRADLEY: *[voice-over]* We wanted to ask Mutual of Omaha why they failed to include Dr. Becker's letter, but they wouldn't talk to us. After Raicht conducted a two-year letter-writing campaign and hired a lawyer, Mutual finally agreed to pay for his hydrotherapy.

[interviewing] You have fought them all along, whenever —

LARRY RAICHT, Multiple-Sclerosis Patient: Yes, I have.

BRADLEY: You write 75 letters a year to them. You're a fighter.

Mr. RAICHT: At a minimum.

BRADLEY: You're persistent.

Mr. RAICHT: Yes.

BRADLEY: What happens to people who are not as stubborn, who are not as persistent as you?

Mr. RAICHT: Well, I suspect that this is why they do what they're doing. I suspect that they do it because they know that 95 percent of the people will not fight, 95 percent of the people will simply say, "Well, I don't have the money and I can't afford it and, if they won't pay it, then I guess I'll just have to go without it."

BRADLEY: Raicht argues insurance companies are likely to turn down valid claims because, after the Supreme Court decision, the worst thing that can happen to the companies is that they'll have to pay what they owed in the first place and not a penny more.

Rep. BERMAN: As long as there are no penalties for unconscionable refusals to pay a claim or arbitrary decisions to cancel policies, they are in fat city.

BRADLEY: *[voice-over]* Congressman Berman is behind an effort in Congress to enable people in group health plans to sue their insurance companies. Carl Shramm, the spokesman for the health-insurance industry, is against it.

CARL SHRAMM, Health-Insurance Industry Spokesman: If any lawyer sees anything that is remotely questionable — and you know this is the fact in our society today — that person will immediately go to court. The insurance company will be asked to defend. It's extremely costly, both to taxpayers and to insurance premium payers, to support this type of decision-making.

Mr. SHERNOFF: If they know they're going to get penalized for cheating somebody, they won't cheat the next person.

BRADLEY: *[voice-over]* Attorney Bill Shernoff.

Mr. SHERNOFF: If they know they have immunity from all prosecution — all lawsuits, all damages — when they cheat somebody deliberately or do something maliciously, they'll do it again and again and again, because they save money.

BRADLEY: So now the only ones who can impose penalties on insurance companies in cases like Steve Spain's and Larry Raicht's are the state insurance regulators — and what kind of job are they doing? In California, about 50,000 people a year file complaints with the insurance department.

[interviewing] One of them was Julie Brown. Before she had her baby, her insurance agent told her and her employer that health coverage for the baby would be automatic once the child was born, but after complications at birth left a large medical bill, Brown applied for the coverage she'd been promised and was turned down.

JULIE BROWN, Turned Down for Insurance Coverage: They're taking the money out of my check every week for insurance and have been since I started, and now it's time for me to collect and they're saying "no."

BRADLEY: *[voice-over]* So Julie Brown, who was stuck with an $8,000 medical bill she couldn't afford, asked for help from the state insurance department, which told her it couldn't do a thing.

Ms. BROWN: I have been to the person that is supposed to be looking out for me the consumer and they have basically shut the door in my face, and then the insurance commissioner says, "Yes, that's OK. They blatantly are screwing you and that's OK with us."

BRADLEY: *[voice-over]* When we contacted her insurance company, Pan American Life, they agreed she'd been misled by the agent and promised to pay her child's medical bills, so at least Julie Brown won't have to sue her insurance company.

Mr. SHERNOFF: If the insurance commissioner were doing their job, we wouldn't have these lawsuits, because the insurance commissioner would be taking care of helping out these people and getting claims paid.

BRADLEY: *[voice-over]* Not once in the past five years has California insurance commissioner Roxanne Gillespie fined or disciplined a major insurance company for abusive claims practices, so attorney Ray Bourhis sued her for ignoring violations of the insurance code.

RAY BOURHIS, Attorney: And they're required — this is the incredible part — they're required to prosecute these insurance companies.

BRADLEY: But I guess they found nothing wrong there?

Mr. BOURHIS: They found things wrong. They admit that the complaints were valid. They just didn't prosecute them and they didn't even save the evidence.

BRADLEY: *[voice-over]* The judge sided with Bourhis and ordered Gillespie to start appropriate disciplinary action against insurance carriers.

[interviewing] So basically, the judge is saying, "Do your job."

Mr. BOURHIS: He's saying, "Do your job." It's the first time in the history of the United States in any state, to my knowledge, that a state judge has ordered an insurance department to begin doing their job.

BRADLEY: *[voice-over]* We asked Commissioner Gillespie for her side of this story, but she refused to talk to us. In court, though, her attorney argued in many cases she's gotten insurance companies to honor their policies and that she prefers negotiation to confrontation.

[on camera] What kind of deals has she negotiated with insurance companies? This year, she allowed Great Republic Insurance, a company which said it was having financial problems, to terminate 14,000 policy-holders who were already sick or likely to file claims.

[interviewing] One of them is Ruth Seutter, who has breast cancer which was diagnosed three years after she started paying premiums. Seutter asked Commissioner Gillespie's office for help.

RUTH SEUTTER, Breast-Cancer Patient: They told me that it was OK to cut people who were costing the company money people who they had had bad claims experience with — and I was one of those people.

BRADLEY: "OK"? Why?

Ms. SEUTTER: Because they needed to generate revenues and the way to do that was to cut people who were sick who were costing the company money.

BRADLEY: *[voice-over]* Great Republic is still selling health insurance in California. Like every other insurance company we contacted, Great Republic declined an on-camera interview, so we told Carl Shramm, the spokesman for the health-insurance industry, about what happened to Ruth Seutter. Even he couldn't believe it.

Mr. SHRAMM: That is not fair. It is wrong. It is illegal and it is reprehensible.

BRADLEY: They offered this person a so-called "conversion" policy and, under that conversion policy, the company charges three times the original premium and will pay one-tenth the benefit. Is that fair?

Mr. SHRAMM: No, I don't think it's fair and I don't think, in many instances, it is acceptable and, in many instances, it wouldn't be legal.

Ms. SEUTTER: If they can do that to me, that means we're all at risk if we become ill. If we have a policy now and we're healthy and we pay our premiums and we do our part, if we become sick we can all be canceled.

BRADLEY: In California, the person who feels aggrieved gets nowhere with the California insurance regulator.

Mr. SHRAMM: I suggest that the person you have to talk to is the head of the California insurance department.

BRADLEY: Well, believe me, I've tried. Believe me, I've tried. The person who is head of the California insurance department won't talk to us.

Mr. SHRAMM: I have no idea why the public official in the state of California who has the legal obligation to regulate the insurance market in that state is not ready or anxious to talk to you about these situations.

BRADLEY: You think she should?

Mr. SHRAMM: Absolutely.

Ms. SEUTTER: This story seems so unbelievable to me — and I'm living it — that if I didn't know me and I didn't know the situation, I would say, "She must have done something wrong. She must have forgotten to pay a premium. She must have done something to cause them to cancel her," but the fact is I always paid my premiums and the fact is I've done nothing other than become sick.

BRADLEY: How many cases are there like the ones you've just seen? The insurance companies say they're isolated, but they won't talk about it. Congressman Berman says there are thousands of other cases just like them. That may be one of the reasons why the state of California decided to let the voters choose who they want for their insurance commissioner. Last Tuesday, they did just that — elected a new commissioner to replace Roxanne Gillespie, the appointed commissioner. How did Ms. Gillespie do with the voters? She didn't. She opted not to run.

[Commercial break]